COMMONWEALTH OF MASSACHUSETTS
CENTER FOR HEALTH INFORMATION & ANALYSIS
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DHCFP-403[1]

HOSPITAL STATEMENT OF COSTS, REVENUES, AND STATISTICS

General Instructions

The DHCFP-403, Hospital Statement of Costs, Revenues and Statistics, consists of the following schedules:

[1] DHCFP- 403 was last updated in 2013.

* Required for non-acute hospitals only

GENERAL INSTRUCTIONS

1. The Commonwealth of Massachusetts " Hospital Statement of Costs, Revenues and Statistics ", form DHCFP-403, supersedes all other existing hospital data and cost reporting forms. The DHCFP-403 is mandatory and the requirements for its use and completion have been set forth in regulations and administrative bulletins.

   A "hospital" is defined as any institution, whether operated for profit or charity, that is advertised, announced, established or maintained for the purpose of providing diagnostic, medical, surgical, or restorative treatment for patients within or centrally based in the institution, and which is licensed as a hospital by the Department of Public Health under Section 51, Chapter 111 of the Massachusetts General Laws (M.G.L), and any hospital licensed under Section 29, Chapter 19 of M.G.L. An institution that qualifies as a hospital although not licensed by said Department by virtue of its being owned and operated by an agency of the Commonwealth shall be deemed a "hospital" for purposes of these instructions.

2. Filing Requirements:

   A. An electronic version of the DHCFP-403 Cost Report via CHIA's INET Filing System.

   B. 403 Supporting Documentation should be submitted in one PDF file.
      (1) Software edits report with explanation on warning message.
      (2) Supplementary schedule for clarification on costs, revenues and statistics.
      (3) Schedule XXVI 403 Cost Report Signature Page
      (4) A reconciliation between the audited financials and the DHCFP-403 Cost Report for hospital with non 9/30 fiscal year ending.

   C. 403 Malpractice Insurance Supporting Documentation in one PDF file for purpose of calculating Mass Health rate.
      (1) Reconciliation schedule from Premium Invoice / Premium Binder to the As Filed 403 amount.
      (2) Copy of Premium Invoice / Premium Binder.
      (3) Wire Transfers / cancelled checks for payment proof.
      (4) Wire Transfers / cancelled checks for funding of the reserves.

3. Medicare Cost Report
   (1) Hospital Medicare Cost Report CMS-2552-96
   (2) Medicare Home Office Report CMS-287-05 for hospital with Home Office.

4. Hospitals with a Hospital Based Nursing Facility must file the HCF-1 cost report on a fiscal year basis consistent with the fiscal year used in the DHCFP-403 cost report. Please refer to 114.2 CMR 5.00 and instructions to the HCF-1 and HCF-1 403 reconciliation report.

5. The accrual basis of accounting and related statistical data is required for reporting to CHIA. Governmental institutions that operate on a cash basis of accounting may submit cost and charge data on such basis subject to appropriate treatment of capital expenditures.

7. All information must be presented in a manner that conforms to the DHCFP Hospital Uniform Reporting Manual (HURM) which serves to establish uniform reporting. Use of DHCFP Hospital Uniform Reporting Manual (HURM) is mandatory; however, these Instructions supersede HURM in any instances where the instructions require the adherence to Medicare Cost principles or where there are other differences between these instructions and HURM.

8. Do not combine or separate any of the reporting departments. In all instances where subtotals and/or totals are required, completion is necessary. Use whole numbers only (round to the nearest dollar). Where percentage or "real numbers" are required (Schedules XIII, XVI, XXI), two (2) decimal places must be used. Do not use fractions.

9. Existing columns and lines must NOT be altered. Several blank lines are provided in each of the following sections: Ancillary, Routine Acute, Routine ICU, and Outpatient. These lines will be used to report services that are not specified in each section. Use a separate line for each added service in the appropriate section. Expandable lines are located in the service area. ICU line 96 can be expanded to 96.05 and Clinic/Ambulatory line 102 can be expanded to 102.10. The ICU lines will remain separate while the Clinic/Ambulatory line will roll up into Line 102. If more than the available blank lines are needed in any particular section, submit a supplementary schedule in the same format as the original schedule. The totals of each column on the supplementary schedule must be brought forward to the original schedule. Place them on the first blank lines in the area of care to which they pertain and indicate "see suppl. sch.". All lines and columns, including subtotals and totals must be completed.

10. CHIA suggests using the following sequence in completing the schedules. It is presented only as a guide and example. Hospitals may find variations to the sequence that may be more beneficial in expediting their individual reporting:

Schedule I	General Information
Schedule III	Patient Statistics
Schedule IIIA	Reconciliation of Patient Days
Schedule IIIB	Supplementary Information-Observation Beds
Schedule VA	Payer Information
Schedule VB	Medicaid Net Revenue
Schedule VI	Gross Patient Service Revenue
Schedule VII	Other Income and Recovery of Expenses
Schedule VIIA	Amortization of Gains and Losses
Schedule VIIB	Supplementary Schedule- Other Income and Recovery of Expenses
Schedule VIIC	Reconciliation of Other Income
Schedule VIII	Specific Free Care Income
Schedule X	Summary of Non-Patient Expenses
Schedule XI	Preliminary Adjusting Entries
Schedule XIIA&B	Summary of Preliminary Adjusting Entries
Schedule XXV	Physician Compensation
Schedule IX	Direct Expenses
Schedule XIII	Stepdown Statistics
Schedule XIV	Stepdown Expenses - Excluding Capital
Schedule XV	Stepdown Expenses - Including Capital
Schedule XVI	Patient Service Statistics
Schedule XVII	Patient Service Expenses - Excluding Capital
	Schedule XVIIA Routine Inpatient Expenses Net of NonDistinct Unit Observation Beds Expenses- Excluding Capital
Schedule XVIII	Patient Service Expenses - Including Capital
	Schedule XVIIIA Routine Inpatient Expenses Net of NonDistinct Unit Observation Beds Expenses- Including Capital
Schedule XXIII*	Financial Statements
Schedule VIA	Reconciliation of Patient Service Revenue
Schedule IXA	Reconciliation of Expenses
Schedule IV	Supplementary Information
Schedule II	Summary Schedule
Schedule XXVI	Certification Statement
Schedule XXVII	Hospital Supplemental Cost Reporting
Schedule XXVIII	340B Annual Pharmacy Reporting

* Required for non-acute hospitals only. Audited Financial Statements will not be accepted in lieu of these Schedules. All Schedules must be completed as presented. Variations of data between Schedules of DHCFP-403 and the Audited Financial Statements must be accompanied by reconciliation.

Schedule I: General Information

Fill in the hospital's tax ID number, the processing date, the start date of the fiscal year, the end date of the fiscal year, the name of the parent company, the number of days in the fiscal year, the DPH provider ID number, what campuses are included in the filing, the vendor, and the type of hospital.

Fill in the name, address, and telephone number of the hospital, Chairman of the Board of Trustees, Chief Executive Officer, Chief Financial Officer, and the person to be contacted with questions about this report.

Schedule II: Summary Schedule

The data reported on this schedule is the by-product of other reporting schedules of the DHCFP-403. Thus it is recommended that its completion be by-passed until all other pertinent schedules have been completed.

Column 2	Expense before Reclassification is posted from Schedule IX, Column 8.
Column 3	Direct Expense is posted from Schedule IX, Column 12.
Column 4	Expense after Stepdown, Excluding Capital, is posted from Schedule XIV, Column 25.
Column 5	Expense after Stepdown, Including Capital, is posted from Schedule XV, Column 25.
Column 6	Patient Service Expense by Department, Excluding Capital, is posted from Schedule XVII: **For Ancillary Services** - columns 5 through 38, line 37. **For Routine Services** - column 3, lines 1 through 36. **except the following lines for hospitals that completed Schedule XVIIA** (Routine inpatient expense net of NonDistinct Observation beds -excluding capital): Line 79 should be posted from Schedule XVIIA column 11, line 1. Line 80 should be posted from Schedule XVIIA column 11, line 2.

Line 81 should be posted from Schedule XVIIA column 11, line 3.

Line 82 should be posted from Schedule XVIIA column 11, line 4.

Line 83 should be posted from Schedule XVIIA column 11, line 5.

Line 85 should be posted from Schedule XVII column 11, line 7.

Line 86 should be posted from Schedule XVIIA column 11, line 8.

Line 87 should be posted from Schedule XVIIA column 11, line 9.

Line 109 should be posted from Schedule XVIIA column 9, line 10.

For Non Patient Care and Other-Column 2, lines 38 through 40 to lines 117 through 119; column 2, line 43 to line 121; column 2, lines 44 and 44.01 to lines 123 and 123.01.

Column 7

Patient Service Expense by Department, Including Capital, is posted from Schedule XVIII:

For Ancillary Services - Columns 5 through 38, line 37.

For Routine Services - Column 3, lines 1 through 36, except the following lines for **Hospitals that completed Schedule XVIIIA** (Routine inpatient expense net of NonDistinct observation beds -including capital):

Line 79 should be posted from Schedule XVIIIA column 11, line 1.

Line 80 should be posted from Schedule XVIIIA column 11, line 2.

Line 81 should be posted from Schedule XVIIIA column 11, line 3.

Line 82 should be posted from Schedule XVIIIA column 11, line 4.

Line 83 should be posted from Schedule XVIIIA column 11, line 5.

Line 85 should be posted from Schedule XVIII column 11, line 7.

Line 86 should be posted from Schedule XVIIIA column 11, line 8.

Line 87 should be posted from Schedule XVIIIA column 11, line 9.

Line 109 should be posted from Schedule XVIIIA column 9, line 10.

For Non Patient Care and Other-Column 2, lines 38 through 40 to lines 117 through 119; column 2, line 43 to line 121; column 2, lines 44 and 44.01 to lines 123 and 123.01.

Column 8

Gross Revenue by Department is posted from: Schedule VI, Columns 5 through 38, Line 37 for Ancillary Services; Schedule VI, Column 3 Lines 1 through 36 for Routine Services; and Schedule VI, Column 2, Lines 38 through 41 for Non Patient Services.

Column 9

Expense by Service, Excluding Capital, is posted from Schedule XVII, Column 2, except the following lines for **hospitals that completed Schedule XVIIA** (Routine inpatient expense net of NonDistinct observation beds -excluding capital):

Line 79 should be posted from Schedule XVIIA column 13, line 1.

Line 80 should be posted from Schedule XVIIA column 13, line 2.

Line 81 should be posted from Schedule XVIIA column 13, line 3.

Line 82 should be posted from Schedule XVIIA column 13, line 4.

Line 83 should be posted from Schedule XVIIA column 13, line 5.

Line 85 should be posted from Schedule XVIIA column 13, line 7.

Line 86 should be posted from Schedule XVIIA column 13, line 8.

Line 87 should be posted from Schedule XVIIA column 13, line 9.

Line 109 should be the sum of Schedule XVIIA column 9, line 10 and column 10, line 10.

Column 10

Expense by Service, Including Capital, is posted from Schedule XVIII, Column 2, except the following lines for **hospitals that completed Schedule XVIIIA** (Routine inpatient expense net of NonDistinct observation beds -including capital): The Schedule II

Line 79 should be posted from Schedule XVIIIA column 13, line 1.

Line 80 should be posted from Schedule XVIIIA column 13, line 2.

Line 81 should be posted from Schedule XVIIIA column 13, line 3.

Line 82 should be posted from Schedule XVIIIA column 13, line 4.

Line 83 should be posted from Schedule XVIIIA column 13, line 5.

Line 85 should be posted from Schedule XVIIIA column 13, line 7.

Line 86 should be posted from Schedule XVIIIA column 13, line 8.

Line 87 should be posted from Schedule XVIIIA column 13, line 9.

Line 109 should be the sum of Schedule XVIIIA columns 9, line 10 and column 10, line 10.

Column 11

Gross Revenue by Service is posted from Schedule VI, Column 2.

Columns 12 & 13

Full-time equivalents (FTEs) for all non-physician employee categories must relate to the departments for which salaries and wages are reported on Schedule IX, Column 2. To compute these FTEs:

> Divide the total annual paid hours (including vacation, sick leave and overtime) for this category of employees in each cost center by 2080 hours.

FTEs for physician categories, **other than interns, externs, residents and fellows**, must relate to the departments for which

salaries and wages and other payments are reported on Schedule XXV, Physician Compensation. These FTEs must be the number of physicians paid, under either compensation or contracted arrangements.

For physicians who render service on less than a full time basis, accumulate the total days worked on an annual basis and divide by 260.

Hours for the calculation of FTEs for interns, externs, residents and fellows should be accumulated by the facility where the service was performed regardless of source of payment. All paid and unpaid hours must be accumulated. Facilities which loan interns, externs, residents or fellows to other hospitals on rotation may not accumulate hours for service performed at these other facilities. To compute these FTEs:

> Divide the total hours accumulated as defined above for this category of personnel in each cost center by 2080 hours.

Record FTEs in whole numbers carried to two decimal places, (e.g., 65.50, not 65½).

Do not use fractions.

Column 14 — Number of Units are posted from Schedule XVI, Columns 5 through 38, Line 37 for Ancillary Services; Schedule XVI, Column 3, Lines 1 through 41 for Routine Services, and Non Patient Care.

Column 15 — Unit of Measure is listed according to the Hospital Uniform Reporting Manual (HURM).

Schedule III: Patient Statistics

1. The data reported on this schedule is hospital utilization information. It must be consistent across Columns 2 through 13 and should correspond to the departments for which data is reported by Payer Information (Schedule VA), Gross Patient Service Revenue (Schedule VI), Direct Expenses (Schedule IX), Stepdown Statistics and Expenses (Schedules XIII, XIV, and XV), and Patient Service Statistics and Expenses (Schedules XVI, XVII, XVIII).

2. For purposes of this schedule, the following terms have the following meaning:

a. Weighted Average Available Beds (Column 2) is defined as the average number of licensed beds which were physically available for immediate patient use, excluding beds not immediately available because of renovation or maintenance, physical plant problems, or similar issues. This number will be calculated as follows: the sum of the number of calendar days each bed was available, divided by 365 (366 in leap years).

b. Weighted Average Staffed Beds (Column 3) is defined as the average number of staffed beds over the entire year. It is calculated as follows: the sum of the number of calendar days each available licensed bed was staffed for use by patients, divided by 365 (366 in leap years). If a bed was staffed for less than 24 hours in any given day, include the appropriate portion of the day that the bed was staffed. For example, if the bed was set up and staffed for only 12 hours, then only 1/2 day should be included in the calculation for that bed.

c. Weighted Average Licensed Beds (Column 4) is defined as the average number of licensed beds over the entire year. It is calculated as follows: the sum of the number of calendar days each bed was licensed, divided by 365 (366 in leap years).

3. Inpatient Days (Column 6) includes all days of care for all patients admitted to each unit. Include the day of admission, but <u>not</u> the day of discharge or death. If both admission and discharge or death occur on the same day, the day is considered a day of admission and counts as one patient day. The number of patient days shall be taken from daily midnight census counts. **NOTE**: Equivalent Observation Beds days should not be included in col. 6.

4. Newborn Infant days incurred in the well-newborn nursery after the mother's discharge (Boarders), as well as infants born outside the hospital and admitted to the well-born nursery, as opposed to an intensive care nursery, must be reported as Newborn Nursery Days (Column 6, Line 20).

5. Percentage of Occupancy (Column 7) is the quotient of Inpatient Days (Column 6) divided by the quantity “Weighted Average Staffed Beds” (Column 3) times 365 (or however many days are in the reporting period). This number is calculated automatically by the software program.

6. Average Daily Census (Column 8) is the quotient of Inpatient Days (Column 6) divided by 365 days and is rounded off to two decimal places. In leap years, 366 days will be used.

7. Admissions (Column 9) must reflect only patient admissions to the hospital. Transfers into a unit must be recorded under Transfer In (Column 10).

8. Total Transfers In (Column 10) must equal total Transfers Out (Column 11). These are the transfers from one unit of the same hospital to another unit, of the same hospital. They should not include transfers between hospitals.

9. Discharges (Column 12) must reflect only patient discharges from the hospital including deaths. Transfers out of a unit must be recorded under Transfer Out (Column 11).

10. Average Length of Stay (Column 13) is the quotient of Inpatient Days (Column 6) divided by the sum of Discharges (Column 12). For **ICU only** column 13 is the quotient of column 6 divided by the sum of Discharges (column 12) **plus** (column 11) Transfers Out.

11. List the number of Medical Admissions, Surgical Admissions, Deliveries, and Newborn Boarder Days, as required, on lines 23 through 26.

12. Report the Fiscal Year End Date and list the Inpatient Days by month corresponding to the fiscal year.

13. With regard to license data, specify: the license classification, e.g., General with Maternity, General without Maternity, Chronic, Rehabilitation, Psychiatric, etc.; the license number; the date that the license was issued; and the date of any license amendments that occurred during the current license period.

14. Existing columns and lines must NOT be altered. Several blank lines are provided in each of the following sections: Routine Acute and Routine ICU. These lines will be used to report services that are not specified in each section. Use a separate line for each added service in the appropriate section. If more than the available blank lines are needed in any particular section, submit a supplementary schedule in the same format as Schedule III. The totals of each line on the supplementary schedule must be brought forward to schedule III. Place them on the first blank lines in the area of care to which they pertain and indicate "see suppl. sch.". All lines including subtotals and totals must be completed.

Schedule IIIA: Reconciliation of Patient Days

1. This schedule should be completed when the detail of patient days on schedule III does not agree with the detail of patient days on schedule VA.

2. Complete all lines where differences exist between schedule III and VA. Example: The hospital has reported patient days on schedule III for M&S as well as Pediatrics. However, the Schedule VA pediatric days line is blank and Schedule IX has no cost. Reconciliation, as well as an explanation for differences, should be reported on schedule IIIA.

Schedule IIIB: Supplementary Information- Observation Beds

The purpose of this schedule is to obtain supplementary information on observation beds regardless whether it is a Distinct unit, a NonDistinct unit or both...

Hospitals with a distinct unit only for Observation Beds must complete section A. A distinct unit must be separately costed as an Outpatient Cost Center and observation patients are only admitted to this area. Revenues, costs, and statistics should be reported on the designated outpatient cost center line in the appropriate schedules.

Hospitals without a distinct unit for Observation Beds must complete section B. Revenues should be reported on the designated outpatient cost center line 31, Schedule VI. Also, refer to schedules VA and XVI for reporting the number of visits. Since the NonDistinct unit cannot be separately costed, the expenses will be allocated on schedules XVIIA and XVIIIA.

Hospitals that admit Observation Patients to inpatient units as well as having a Distinct Observation Unit must complete both sections A and B. Revenues for both distinct and non-distinct observation should be combined on Schedule VI and the direct costs of the distinct unit should be reported on the designated outpatient cost center on Schedule IX. The combined distinct and non-distinct observation visits should be recorded by payor on Schedule VA and the Distinct Unit ancillary statistics should be recorded on Schedule XVI.

Schedule IV: Supplementary Information

1. The information on this schedule will provide answers regarding hospital teaching programs, changes in beds, new/discontinued services, organizational changes, physician transfers-on and off, determination of need projects, personnel staffing and RN/LPN/C.N.A wage information.

2. For clarification, the following definitions are provided:

    a. A Physician/Hospital Organization is a legal entity jointly controlled by a hospital or holding company, and physicians -- either groups, IPA, or MD classes -- where joint risk- sharing is implied. The PHO entity may contract services to HMOs/PPOs and self- insured employers, and revenues are paid to the PHO and distributed to its owners according to the PHO bylaws.

    b. An Affiliation is a formal, association with another healthcare provider organization (do not include physicians with general admitting privileges).

c. A Referral is a formal, written agreement for the referral of patients from one provider to another, where there is a formal financial arrangement between the two providers.

d. Other should include other network arrangements.

3. The total number of Full-Time Equivalents, Section C, Line 11, must agree with the sum of Schedule II, Columns 12 and 13, Line 122.

4. Section D: RN/LPN/CNA Salary and Benefit Data

a. Data should be reported for hospital personnel only. Do not include personnel who are employed by temporary staffing agencies or per diem staff.

b. Salaries and wages must include any base wage, salary, or bonus payments. Do NOT include shift differentials and overtime differentials paid to the employee. Do NOT include the employer's share of payroll taxes.

c. Shift and overtime differential wages include any amounts paid above an employee's base wage to compensate for working a second, third, weekend shift, or as remuneration for overtime worked. The amount reported must only include payments related to the differential only. The base wages must not be reported under this column.

d. Registered Nurse Specialist is defined as a Registered Nurse with advanced nursing knowledge and clinical skills acquired through an appropriate nursing education program in accordance with 244 CMR 4.00, and includes, but is not limited to, Operating Room Nurses, Clinical Nurse Specialists, Intensive Care Unit Nurses, Coronary Care Unit Nurses, and Infection Control Nurses.

5. Section E. MASSHEALTH PROVIDERS INCLUDED IN THE 403

All hospitals are required to disclose all MassHealth providers whose expenses and revenues are reported on the DHCFP-403. Hospitals must list the MassHealth provider number, the organization name if different from the hospital, the Medicare provider number, and the address if different from the hospital for inpatient and outpatient services.

Schedule VA: Payer Information - Required for All Hospitals

1. There are eleven (11) categories for this Schedule. They are: Medicare, Medicaid, Workers Compensation, Self Pay, Other Government, Managed Care, Non-Managed Care, Other, Commonwealth Care, Health Safety Net and Non-Patient.

Column 2 Subtotal Columns 3 through 14

Column 3 **MEDICARE MANAGED CARE** should contain:

Mcare MC-Enhance (Pilgrim Product)
Mcare MC-Health New England Medicare Wrap
Mcare MC-HMO Blue for Seniors
Mcare MC-Kaiser Medicare Plus Plan
Mcare MC-Matthew Thornton Senior Plan
Mcare MC-Tufts Medicare Supplement (TMS)
Mcare MC-Other (not listed elsewhere)
Mcare MC-Fallon Senior Plan
HCHP 1st Seniority
Seniorcare Direct /Plus
Mcare MC-Other (not listed elsewhere)

Column 4 **MEDICARE NON-MANAGED CARE** should contain:

Medicare
Out-of-State Medicare
Medigap Non-Managed Care*
AARP / Medigap
Banker's Life & Casualty Insurance
Banker's Multiple Line
BCBS Medex
Combined Insurance Company of America
Other Medigap (not listed elsewhere)

Column 5 **MEDICAID MANAGED CARE** should contain:

Mcaid MC- Community Health Plan
Mcaid MC-Central Mass Health Care
Mcaid MC-Fallon Community Health Plan
Mcaid MC-Harvard Community Health Plan
Mcaid MC-Health New England
Mcaid MC-HMO Blue
Mcaid MC-Kaiser Foundation Plan

Mcaid MC-Mass Behavioral Health Partnership
Mcaid MC-Neighborhood Health Plan
Mcaid MC-United Health Plans of NE
Mcaid MC-Pilgrim Health Care
Mcaid MC-Tufts Associated Health Plan
Mcaid MC-Other (not listed elsewhere)

Column 6 **MEDICAID NON-MANAGED CARE** should contain:

Mcaid MC-Primary Care Clinician (PCC)
Massachusetts Medicaid

Column 7 **WORKER'S COMPENSATION** should contain Workers' Compensation

Column 8 **SELF PAY** should contain Self Pay (insurer does not cover services or foreign insurer is not accepted) and Free Care for patients that are not eligible for the Health Safety Net (out of state).

Column 9 **OTHER GOVERNMENT** should contain CHAMPUS, DMH, DPH, DSS, Other Mass. State and Local Agencies, Out-of-State Government Agencies, and Out-of-State Medicaid

Column 10 **MANAGED CARE** (MC) should contain:

BLUE CROSS MANAGED CARE:
Bay State Health Care
Blue Care Elect
Blue Choice (includes HealthFlex Blue)
Commonwealth PPO
HMO Blue
Network Blue (PPO)
Other Blue Cross Managed Care

COMMERCIAL MANAGED CARE:
CIGNA Health Plan
CIGNA PPO
John Hancock Preferred
Mass Mutual
MetLife Point of Service
Met-Elect
MetLife Healthcare Network of Mass
Phoenix Preferred PPO
Pru Network PPO

Prucare
PRUCARE of Mass
Prucare Plus (Point of Service)
Travelers Preferred
Other Commercial MC (not listed elsewhere)

HMO MANAGED CARE:

(Capital Area) Community Health Plan
Central Mass Health Care
Fallon Community Health Plan
Harvard Community Health Plan
HCHP of New England (formerly RIGHA)
Health New England, Inc.
Health Source New Hampshire
HMO Rhode Island
Kaiser Foundation
Matthew Thornton
MEDTAC
Neighborhood Health Plan
Ocean State Physician Plan
Pilgrim Health Care
Pioneer Plan
Tufts Associated Health Plan
United Health Care of New England (Ocean State)
US Healthcare
Other HMO (not listed elsewhere)

PPO & OTHER MANAGED CARE:

ADMAR
Advantage (Pilgrim product)
Central Mass Health Care-Central Plus
Community Health Plan Options
Freedom Care (Sentry Life)
Health New England Advantage
Healthsource Preferred (self-funded)
Options for Healthcare PPO
Pioneer Health Care PPO
Psychological Health Plan
Tufts Total Health Plan PPO
PPO and Other MC (not listed elsewhere)

Column 11 **NON-MANAGED CARE** should contain:

BLUE CROSS:

Blue Cross Indemnity

COMMERCIAL INSURANCE:

Aetna Life Insurance
Boston Mutual Insurance
Connecticut General Insurance
Continental Assurance Insurance
Great West/NE Care
Guardian Life Insurance
Hartford L&A Insurance
John Hancock Life Insurance
Liberty Life Insurance
Liberty Mutual
Lincoln National Insurance
Mass Mutual Life Insurance
Metropolitan Life Insurance
Mutual of Omaha Insurance
New England Benefits
New England Mutual Insurance
New York Life Insurance
Paul Revere Life Insurance
Private Health Care System
Prudential Insurance
Quarto Claims
State Mutual Life Insurance
Time Insurance Co
Transport Life Insurance
Traveler's Insurance
Union Labor Life Insurance
Wausau Insurance Company
Other Commercial (not listed elsewhere)

Column 12 **OTHER** should contain:

Foundations
Research Grants for Patient Care

Column 13 **COMMONWEALTH CARE** should contain:

Network Health Forward Plan Types 1, 2, 3, and 4
Boston Medical Center HealthNet Plan Commonwealth Care Plan Type 1, 2, 3, and 4.

NHP Commonwealth Care Plan Types 1 (9CC1), 2 (9CC2), 3 (9CC3) and 4 (9CC4).
Commonwealth Care FCHP Direct Care Group Nos. 810FA, 810FB, 810FC and 810 FD.

Column 14 HSN should contain all services rendered to eligible and enrolled Health Safety Net patients

Column 15 **NON-PATIENT** should contain:
Services rendered to other than hospital patients
Services to other hospitals and institutions (no third party billing)
Services to doctors and employees (not as patients)

NOTES: Schedule VII contains revenue from laundry sales, sale of radiology film, etc. These services are not included in the hospital's charge book and are not considered as Non-Patient. They should not be recorded on Schedule VA.

* Medigap type plans are usually supplemental to Medicare.

2. There are three (3) reporting areas:

   a. Inpatient Statistics

   b. Outpatient Statistics

   c. Gross Patient Service Revenue, Deductions, Gross Receipts from HSN, and Bad Debts Written Off are divided into Total Inpatient and Outpatient areas.

3. The data reported on this schedule provides utilization, revenue, contractual adjustments, total free care, and bad debts written off information by payer as indicated.

   Payer class should be determined at the time of discharge. Payer information should not be aggregated and reported in "Other".

4. Inpatient Statistics, Lines 1 through 25:

   a. The data for patient days should be taken from subsidiary ledgers by type of payer. Column 2, Lines 1 through 22 must agree with Patient Statistics (Schedule III, Column 6, Lines 1 through 22) and Patient Service Statistics (Schedule XVI, Column 3, Lines 1 through 22).

b. All Administratively Necessary Days (ANDs) must be listed separately, on Line 23, in the appropriate payer class group column, but must also be included in the days listed on Lines 1 through 22.

c. Admissions and Discharges, Column 2, Lines 24 and 25 must agree to Schedule III, Patient Statistics, Columns 9 and 12, Line 22.

5. Outpatient Statistics, Lines 26 through 39:

a. **Please note that the proper statistic for Ambulatory Surgery is number of visits.**

b. Outpatient statistics should be taken from subsidiary ledgers by type of payers for all Ambulatory Care Services as outlined in HURM. **Note: Number of visits for Observation Beds should be reported on line 34 whether it is a Distinct unit or a NonDistinct unit, not the calculated days from Schedule IIIB.**

c. Column 2, Line 39 must agree with Schedule XVI, Patient Service Statistics, Column 3, Line 36.

d. Private Referrals, Line 35 should not have routine visits included on this schedule.

6. Gross Patient Service Revenue and other information, Lines 40 through 80:

Note: For purposes of this report, the matching of revenue and expenses is imperative. A patient was admitted through the Emergency Room will have that Emergency Room Revenue reported in the Emergency Room cost center.

a. The data for Gross Patient Service Revenue should be taken from subsidiary ledgers by type of payor.

Column 2, Line 40, Inpatient Routine GPSR should agree with Schedule VI, Column 3, Line 22.

Column 2, Line 41, Inpatient Ancillary GPSR should agree with Schedule VI, Column 4, Line 22.

Column 2, Line 42, Outpatient Routine GPSR, should agree with Schedule VI, Column 3, Line 36.

Column 2, Line 43, Outpatient Ancillary GPSR, should agree with Schedule VI, Column 4, Line 36.

Column 2, Line 44, Total GPSR, should agree with Schedule VI, Column 2, Line 37.

b. Deductions, Lines 45 through 49 for Contractual Adjustments and Free Care should be taken from subsidiary ledgers by type of payer.

1) **Line 45, Contractual adjustments represent the difference between full established charges for individual services and the contractual rates with third party payers for services rendered. Providers may NOT allocate contractual adjustments across payers using such allocation mechanisms as charges, patient days, discharges or any other statistic or allocation method.**

2) Line 50, Total Free care includes charity services which represent the uncollectible amount of the hospital's full established rates for services rendered to financially indigent patients and policy discounts which represent adjustments for items such as courtesy allowances and employee discounts from the hospital's full established rates for services. Charity services and policy discounts may range up to 100% of regular charges. HSN claims should be recorded in line 46 of Column 14.

c. Line 52, Gross Receipts from Health Safety Net should include all payments received from the Health Safety Net. NOTE: Gross Health Safety Net Assessment should be reported on Sch. IX, line 123.01.

d. Changes resulting from finalizing prior years' **third-party settlements must be reflected in the net patient service revenue on line 52.01 through contractual adjustments on line 45.**

e. Deductions related to the provision for bad debt must be reflected in the net patient service revenue on line 52.01 through contractual adjustments on line 45. Continue to report the provision separately on line 53, which has no effect on NPSR in line 52.01.

f. Line 52.02, Total Premium Revenue. Premium Revenue is revenue derived from capitation arrangements. These revenues are generated from the fees paid based on a contract between a prepaid health care plan and the provider.

1) The sum of line 65.02, I/P Premium Revenue and line 78.02, O/P Premium Revenue should equal Line 52.02, Total Premium Revenue.

2) Premium Revenue **should be included in NPSR** through the contractual adjustment line, line 45

g. Line 53, Provision for Bad Debts is an input line Columns 3 through 13, with Column 2 being a formula to calculate total Provision.

h. Line 54, Bad Debts Written off should be taken from subsidiary ledgers by type of payer. Bad Debts Written off represent actual bad debts written off from patient accounts receivable in the current year.

i. The Gross Patient Service data on lines 55, Inpatient Routine, 56, Inpatient Ancillary, 68, Outpatient Routine, and 69, Outpatient Ancillary, must agree with the data on lines 40, 41, 42, and 43 respectively.

j. The data on lines 58 through 65 and lines 71 through 78 is required for the Medicare Managed and Non-Managed columns, the Medicaid Managed and Non-Managed columns and for the Total column. The total of Net Inpatient Revenue (line 65.01) and Net Outpatient Revenue (line 78.01) should agree with Total Net Patient Service Revenue (line 52.01).

j. Line 66, Provision for Inpatient Bad Debt, is an input line through column 6.

k. Complete applicable data for all columns for lines 67 and 80.

Schedule VB: Medicaid & HSN Net Revenue

Schedule VB requires hospitals to report a detailed summary of the Medicaid and HSN amounts reported on Schedule VA.

In accordance with general HCF-403 reporting requirements, schedule VB must be completed using the accrual method.

The amounts on Schedule VB, line 13, Columns 3 through 7, must equal the amounts on Schedule VA, lines 58 and 71 (contractual adjustment).

1. Gross Patient Service Revenue (line 1). This is the amount reported on Schedule VA for the appropriate payer source.
2. Base Rate Revenue (line 2). Report the total revenue from each source for services provided. For Medicaid, such revenue would include, but not be limited to, inpatient Standard Payment Amount per Discharge revenue (SPAD), transfer per diem revenue, administrative day revenue, per diem revenue for mental health services, Payment Amount Per Episode (PAPE) revenue, and other fee schedule based revenue to the hospital, such as

laboratory services. For Health Safety Net, Base Rate Revenue includes revenue only from the Health Safety Net.

3. Specified Disproportionate Share Revenue (lines 3 & 4). Report the total amount for these DSH sources in the appropriate categories. Hospitals may allocate this revenue to inpatient or outpatient Medicaid and HSN columns.
4. Safety Net Revenue (line 5). Report DSH revenue by "safety net providers" in accordance with the provisions of 114.1 CMR 36.07(4).
5. Supplemental Revenue (lines 6-8). Report the total revenue from any supplemental rate source. If the revenue is funded by an Intergovernmental Transfer (IGT) arrangement, report the gross amounts (i.e. federal and non-federal shares).
6. Other Revenue (lines 9-11). Report any additional revenue amounts for patient services from Medicaid, Medicaid Managed Care Programs, or HSN.
7. Subtotal: Revenue (line 12). Sum the total revenue reported on lines 2 through 11.
8. Contractual Adjustment (line 13). Subtract Subtotal: Revenue (line 12) from Gross Patient Service Revenue (line 1).

Schedule VI: Gross Patient Service Revenue

1. The data reported on this schedule aggregates Gross Patient Service Revenues by Inpatient, Outpatient and Non-Patient Services. It must correspond to the departments for which data is reported on Patient Statistics (Schedule III), Payer Information (Schedule VA), Direct Expenses (Schedule IX), Stepdown Statistics and Expenses (Schedules XIII, XIV, and XV), and Patient Service Statistics and Expenses (Schedules XVI, XVII, and XVIII).

2. Existing columns and lines must NOT be altered. Several blank lines are provided in each of the following sections: Routine Acute, Routine ICU, and Outpatient. These lines will be used to report services that are not specified in each section. Use a separate line for each added service in the appropriate section. There are five additional columns for any added ancillary services. These columns will be used to report ancillaries not already specified. Use a separate column for each added ancillary. A description is required for any new ancillary, cols. 34 through 38. If more than the available blank lines and/or columns are needed in any particular section submit a supplementary schedule in the same format as Schedule VI. All lines and columns, including subtotals and totals must be completed. If the hospital files a supplemental schedule, transfer the total of the lines to the first blank line in the area of care to which they pertain and indicate “See Suppl. Schedule". For more than five (5) new ancillaries, the aggregate totals on the supplemental schedule should be brought forward to column 34 and headed "See Suppl. Schedule".

3. The data required for this schedule should be taken from the hospital's general and subsidiary ledgers. It is reported in three (**3**) major categories:

a. Routine Services: Routine Gross Patient Service Revenue should be reported in Column 3, Lines 1 through 22 for Inpatient. Routine Gross Patient Service Revenue should be reported in Column 3, Lines 23 through 36 for Outpatient.

b. Ancillary Services: Ancillary Gross Patient Service Revenue should be reported by type of service, Columns 5 through 38, according to HURM, from the hospital's ledgers and summed in Column 4, for Inpatient and Outpatient, Lines 1 through 37.

NOTE: Gross Patient Service Revenue (Routine and Ancillary) for Observation Beds should be reported on line 31 regardless of whether it is a Distinct unit or a NonDistinct unit.

c. Non-Patient Care Services: With respect to Non-Patient Ancillary, Gross Patient Service Revenue should be posted by type of service, Columns 5 through 38, line 38, and summed in column 4 line 38. These earnings are designated as Non-Patient as services were provided to other than hospital patients and included services to other hospitals and institutions, to doctors and employees (not as patients), and usual patient care services paid for out of research grants.

NOTE: The reference to services sold on Schedule VII, i.e., laundry sales, sale of radiology film, etc., applies to services not included in the hospital's charge book and is not considered a Non-Patient revenue category. Therefore, it should not be recorded on Schedule VI.

4. Total Gross Patient Service Revenue (Column 2, Line 37) should agree with the Audited Financial Statements, and Schedule VA (Column 2, Line 44). Any variations from the Financial Statements, and Schedule VA should be reconciled on Schedule VIA.

Schedule VIA: Reconciliation of Patient Service Revenue

This schedule is used:

1. To reconcile any variations related to Gross Patient Service Revenue between the audited financial statements and Schedules VI and VA, and to reconcile net patient service revenue on Schedule VA to the audited financial statements and to Schedule XXIII (non-acute).

Schedule VII Other Income and Recovery of Expenses

1. Other Income shall include: all revenue received from non-operating services, i.e., cafeteria, gift shops, etc., revenue received from charges made for services rendered or supplies sold to employees, other non-patient and patients through activities normally considered to be related to patient care; as well as revenue from activities in patient care areas which are not related to patient services and for which there is no approved charge. Other income shall also include revenue from unrestricted gifts, investments, and grants.

2. Gains and Losses on disposal of assets, including the demolition of assets, must be reported and recovered.

3. Gains and Losses from investing activities must be reported on Schedule VII. If income/gain on the investment is unrestricted, it must be recovered against related patient care costs, generally interest expense. ***Losses on investments should not be reported as an offset to recovery of expenses.***

4. Gains and Losses on Advance Refunding of debt will be reported on Line 49 and will be amortized in accordance with Medicare principles and the Medicare Provider Reimbursement Manual, Part I, Section 233. Refer to Schedule VIIA for the amortization of gains and losses.

5. All other gains and losses related to patient care (other than those resulting from the sale or disposal of depreciable assets) should be reported on the basis of reasonable cost in accordance with the Medicare Provider Reimbursement Manual, Part I, Section 2160.

6. Recoveries are only those revenues received from the charges made for services considered to be related to patient care. These revenues are recovered as an offset against the expense of the service or supply. Items of income that are recoverable, Column 3, must be offset to the corresponding expense line on Schedule IX. An explanatory note must accompany any recovery of less than 100%. Amount received for *Bad Debt Recoveries* must be indicated on *line 22, column 2 <u>only</u>*. All revenues received for non-patient services are not recoverable ***only if*** expenses are located in the Non-Patient section of Schedule IX and described on Schedule X.

7. Existing lines must not be altered. If categories of Other Income do not coincide with the hospital's nomenclature, use "Other," Line 47, as a single category and submit a supplementary schedule (Schedule VIIB) in the same format as the original showing the component parts of the combined category.

8. All hospitals with Other Income and Recovery of Expenses must complete Schedule VII.

<u>Schedule VIIA: Amortization of Gains and Losses</u>

This schedule should be used for the amortization of accounting gains and losses.
Losses should be entered as negative while gains should be entered as positive amount.

Column 1 Enter the description of each item to be amortized.

Column 2 Enter the year that the amortization will begin.

Column 3 Enter the year that the amortization will end.

Column 4 Enter the amount to be amortized. This amount should reconcile to the audited financial statements.

Column 5 Enter the periods (years) that the amount in column 4 will be amortized over.

Columns 6-18 Enter the amounts that will be amortized in the current year and subsequent years.

Lines 1-15 List each accounting gains or losses separately on lines 1-15.

Total Calculate totals for all columns where values appear. The current year's total should be carried forward to Schedule VII.

Schedule VIIB: Supplementary Schedule- Other Income and Recovery of Expenses

This schedule should be used to detail the component parts of the single category "Other" on Schedule VII, line 47. The format will be the same as the original Schedule VII.

Schedule VIIC: Reconciliation of Other Income

This schedule should be used to reconcile any variations between Schedule VII, Schedule XXIII, and the Audited Financial Statements related to Other Revenue and Net Non-Operating Gain/Loss.

Schedule VIII: Specific Free Care Income

Free Care Income means the aggregate of (**1**) all principal, if any, applied by the hospital to providing Free Care, (**2**) all income, if any, (current or accumulated) so applied or so applicable which is earned on all funds limited by gift to providing any restricted form of Free Care, (**3**) all current income if any, earned on all funds limited by gift to providing unrestricted Free Care, and (**4**) all income, if any, earned on all other funds which, by determination of the hospital's governing board, is applied to providing Free Care, provided, however, that in no fiscal year shall the aggregate of the hospital's Free Care Income be deemed to exceed the aggregate of its Free Care.

List aggregate Free Care Funds regardless of whether income was earned or not or whether principal was used or not. If there are no Free Care Funds, indicate that there is no Free Care Income.

Schedule IX: Direct Expenses

1. This schedule is the starting point for the determination of cost findings. The data for the completion of this schedule should be taken from the hospital's General Ledger and Plant Ledger. The data should correspond to the departments for which data is reported on Patient Statistics (Schedule III), Payer Information (Schedule VA), Gross Patient Service Revenue (Schedule VI), Stepdown Statistics and Expenses (Schedules XIII, XIV, and XV), and Patient Service Statistics and Expenses (Schedules XVI, XVII, and XVIII).

2. Prior to the completion of this schedule, certain other detailed schedules are necessary with subsequent postings to Schedule IX.

    a. Physician Compensation, Schedule XXV must be completed with the summed result, Column 2, posted to Schedule IX, Column 3.

    b. Preliminary Adjusting Entries, Schedule XI and the Summary of Preliminary Adjusting Entries, Schedule XII must be completed and posted to Schedule IX, Columns 9 and 10.

    c. Other Income and Recovery of Expenses, Schedule VII must be completed and entered on Schedule XI and Schedule XII and then posted to Schedule IX, Column 11.

    d. Non-Patient Expense, Schedule X must be completed and posted to Schedule IX, Lines 118 and 119.

3. Refer to the HURM for a description of each cost center. Existing columns and lines must NOT be altered. Several blank lines are provided in each of the following sections: Ancillary, Routine Acute, Routine ICU, and Outpatient. These lines will be used to report services that are not specified in each section. Use a separate line for each added service in the appropriate section. If more than the available blank lines are needed in any particular section, submit a supplementary schedule in the same format as Schedule IX. The totals of each column on the supplementary schedule must be brought forward to sch. IX. Place them on the first blank lines in the area of care to which they pertain and indicate “see suppl. sch.". All lines and columns, including subtotals and totals must be completed.

4. Direct Expenses are reported in five categories as follows:

a. Salaries and Wages for Non-Physician, (**including interns, externs, residents, and fellows)** employees Col. 2. Amounts recorded must relate directly to Full-Time Equivalents (Schedule II, Column 12). Salaries and wages of personnel who work in more than one department, or service unit, and who are supervised by more than one department, or service unit, must be allocated to the applicable cost centers. Fringe Benefits do not belong aggregated with Salaries and Wages throughout the cost centers, but instead should be recorded separately on Line 6, Fringe Benefits.

b. Physician Compensation **(excluding interns, externs, residents, and fellows)** Col. 3. Amounts recorded must relate directly to Full-Time Equivalents (Schedule II, Column 13), and are posted from Schedule XXV, Column 2.

c. Purchased Services Col. 4. This category includes both: 1) contractual agreements with independent firms or other health care providers which provide such services as housekeeping, laundry, dietary, preventive maintenance, laboratory coverage, etc., and 2) non-contractual services purchased such as laboratory tests, scanning procedures, therapy treatments, etc.. Purchased services constitute any amount in excess of $10,000.00 per vendor per department. Amounts less than $10,000.00 may be considered as supplies.

d. Supplies and Expenses Col. 5. This category includes expenses, which are incurred on a departmental basis, other than items falling within category (**a**) through (**c**) above. Operating leases and rentals of Major Movable Equipment and Building & Fixed Equipment should also be reported in this category of expense, by cost center.

e. **Major Movable Equipment Depreciation Col. 7. Both the depreciation of MME and the amortization of MME-capital lease must be charged to the appropriate cost center. For Acute Care Hospitals, the basis for this entry should be obtained from the Plant Ledger.**

5. The amounts in Column 13, Lines 1 through 43, Expenses to be Stepped Down, are carried forward to Schedule XIV, Column 2, Lines 2 through 21, and Schedule XV, Column 2, Lines 1 through 21.

6. Two overhead cost centers, Central Patient Transportation and Nursing Float, are holding cost centers which, after reclassification, must have a zero balance and cannot be carried forward to column 12 or 13.

a. Central Patient Transportation. This cost center contains the direct expenses incurred in central patient transportation only if there is an established central patient transportation cost center. These costs are then reclassified to the appropriate Ancillary or Routine Care cost center.

b. Nursing Float. The expense of nursing personnel who work in more than one cost center on a "float" basis must be recorded in the cost center in which they work. They should be recorded originally in this account and then reclassified to the appropriate cost center.

7. Fringe Benefits **must** be reported on Line 6 in Column 5. Salaries and Wages for this line would include the administration salaries for these benefits which would be reported in Column 2.

8. The following expenses must be reported in Column 5, on the appropriate lines:

- Ln. 1: Depreciation Expense of Building & Fixed Equipment
- Ln. 2: Amortization Expense of Capital Lease-B&F
- Ln. 3: Interest Long-Term, on Bonds, Mortgages, Capital Lease and Amortization of Bond Discount/ Premium
- Ln. 4: Amortization of Bond Issue Costs
- Ln. 11: Insurance- Professional Malpractice
- Ln. 12: Insurance- Hospital Malpractice
- Ln. 13: Insurance- Other
- Ln. 14: Interest-Short Term
- Ln. 20: Licenses and Taxes (Other than income)
- Ln.123: Provision for Bad Debts ***(Includes both patient and non-patient; do not offset Bad Debt Recoveries against Provision for Bad Debts)***
- Ln.123.01: Gross Health Safety Net Assessment should be the gross payment to the Pool.

Total expenses (C8, L124) should agree with the Audited Financial Statements total expenses. Interest expense (C8, L3&14) should tie to the Audited Financial Statements interest expense. Total Depreciation and Amortization Expenses (C7,L124 + C8,L1,2&4) should also tie to the Financial Statements Depreciation. Any variations from the Financial Statements should be reconciled on Schedule IXA.

9. Central Services & Supplies and Pharmacy Costs, Lines 36 and 37, are to be allocated on the basis of costed requisitions (on the stepdown schedule). Consequently, these cost centers should not have a zero balance after reclassification. However, C.S.R. labor costs in the Central Services & Supplies cost center should be reclassified, prior to stepdown, on the basis of a time study. If the results of a time study are not available all C.S.R. labor costs must be reclassified to the Routine Medical and Surgical Acute cost center (Line 79).

10. Reclassification Credits (Column 10) and Recoveries (Column 11) should be entered as negative integers.

11. Line 123, Provision for Bad Debts is a non-input line.

Schedule IXA: Reconciliation of Expenses

This schedule is used to reconcile any variations from Schedule XXIII and the Audited Financial Statements that may have occurred to Total Expenses, Total Depreciation Expense and Total Interest Expense on Schedule IX.

Schedule X: Summary of Non-Patient Expenses

1. List all non-patient expenses (i.e. coffee shop, gift shop, marketing, lobbying, rental expenses and medical offices) categorized by: 1) salary and wages, and 2)all other.

2. The totals of Column 4, Lines 1 and 2 should be recorded on Schedule IX, Line 118 in the appropriate columns.

3. Column 4, Lines 3 through 19 should be summed and recorded on Schedule IX, Line 119 in the appropriate columns.

4. Column 4, Line 20 Total, must agree with Schedule IX, Column 8, Line 120.

5. Existing lines must not be altered. If descriptions of non-patient expense lines do not coincide with the hospital's nomenclature, use the "Other", Lines 14 through 19.

6. All hospitals with direct non-patient expenses must complete Sch. X.

Schedule XI: Preliminary Adjusting Entries, and
Schedule XII: Summary of Preliminary Adjusting Entries

1. Preliminary Adjusting Entries must be reported on Schedule XI. List the Department debited and the debit amount, the Department credited and the credit amount, and a brief explanation of the adjusting entry. If additional pages are needed, photocopy the original and number the additional pages sequentially.

Schedule XI:

2. a. The summary of the preliminary adjusting entries must be reported on Schedule XII and carried forward to Schedule IX, Columns 9 and 10. Total Debits must equal Total Credits.

   b. In Column 1, enter the line number from Schedule IX that corresponds with the entry.

c. In Column 2, list the name of the department from Schedule IX that corresponds with the entry.

Schedule XII:

d. In Columns 5 through 9, list the amount of the debit and credit of each preliminary entry that sums to the total reclassification in Columns 3 and 4 for each department listed in Column 2.

e. If additional pages are needed, photocopy the original and number the additional column headings and pages sequentially.

3. Hospitals using other formats or multiple composite distributions must submit as an addendum to this schedule, the calculations and basis for the adjustments. Total Debits must equal Total Credits.

4. **Both operating leases and rental costs for Building & Fixed Equipment and Major Movable Equipment are not to be reclassified into capital costs on Schedule IX, Lines 1 through 4, Columns 9 and 10.**

5. Hospitals reporting **Home Office Costs, Physician Foundation** and other similarly related entities' allocated costs **must** report those costs on Sch. XI.

Schedule XIII: Stepdown Statistics

1. This schedule reflects the total statistical base for all departments to be used for the stepdown allocation of expense. The data should correspond to the departments for which data is reported on Patient Statistics (Schedule III), Payer Information (Schedule VA), Gross Patient Service Revenue (Schedule VI), Stepdown Expenses (Schedules XIV, XV), and Patient Service Statistics and Expenses (Schedules XVI, XVII, and XVIII).

2. Statistics must be reported on the basis specified for each department. **Variations and alternative methods will not be accepted unless prior approval, in writing, is obtained from CHIA.**

Existing lines and columns must not be altered. With the advent of new categories of service in the areas of:
(1) Ancillary Care Services, (2) Routine Inpatient, (3) Intensive Care, (4) Clinic and (5) Routine Ambulatory Care services, several blank lines have been provided in each of the four service areas to eliminate bundling. These lines are to be used to report services that are not specified in each category. Use a separate line for each additional service.

In the event that more additional lines are necessary within one of the four categories of service, a line referenced supplementary schedule must be submitted (i.e., Suppl. Sch. XIII-

Line 51 (or 62 or 70 or 89)). The format must be a replication of Schedule XIII with the necessary line descriptions for the additional services and applicable statistics for the pertinent columns. The totals of the statistics for each column on the supplemental schedule must be brought forward onto schedule XIII. Place them on the first of the blank lines in the area of care to which they pertain and indicate "See suppl. sch."

3. **Multiple apportionments within a cost center must have prior written approval by CHIA. Hospitals currently using multiple apportionment methods must annually request approval for the use of this multiple apportionment method. The request must specify the multiple method used, the reason for such usage, any change and the reason for such change from prior reporting periods.**

4. All statistics must be accumulated for a twelve (**12**) month period which must coincide with the financial reporting year.

5. All statistical bases must be reported in each column for all relevant departments and totaled to Line 100. Statistical bases used for the stepdown of expenses shall be summed to Line 101. This sum on Line 101 excludes the statistics from those departments, which do not share in the stepdown.
   For Example: The Housekeeping Department statistical base is Hours of Service. All Hours of Service for Housekeeping are reported in Column 11, Lines 1 through 99 and totaled on Line 100. The statistical base for stepdown for Housekeeping is the Hours of Service summed from Lines 8 through 99 and reported on Line 101. The sum on Line 101 will be the basis for the distribution of expenses on Schedules XIV and XV.

6. In order to allocate costs on the Stepdown Expense Schedules (XIV and XV) a unit cost multiplier must be calculated on Line 102 (excluding capital) and Line 103 (including capital).

   The computation of the unit cost multipliers must be done in conjunction with the completion of Schedules XIV and XV by dividing the costs for stepdown (Schedule XIV, Column 4, Lines 2 through 20) by the total statistics for stepdown (Schedule XIII, Line 101, Columns 6 through 24). For example, after computing Total Expense for Stepdown, Fringe Benefits (Schedule XIV, Column 4, Line 2) divide that amount by the Total Statistics for Stepdown, Fringe Benefits (Schedule XIII, Line 101, Column 6) and record the results on Schedule XIII, Line 102, Column 6 (Unit Cost Multiplier, Fringe Benefits).

   After computing Total Expenses for Stepdown, Administration through Interest Short- Term (Schedule XIV, Column 4, Line 3) divide that amount by the Total Statistics for Stepdown, Administration through Interest Short-Term (Schedule XIII, Line 101, Column 7) and record the result on Schedule XIII, Line 102, Column 7 (Unit Cost Multiplier, Administration through Interest Short-Term). Continue all unit cost multiplier calculations in the same manner for Columns 8 through 24.

Calculate the unit cost multipliers including capital (Schedule XIII, Line 103, Columns 5 through 24) in the same manner, using Total Expense for Stepdown from Schedule XV, Column 4, Lines 1 through 20.

7. The required statistical bases are as follows:

Department	Statistical Base	Definition
Building and Fixed Equipment Depreciation Leases-Amortization Interest-Long Term Amort of Bond Issue	Square Feet " " " "	Square feet should conform to the AHA guidelines for determining net square feet
Fringe Benefits Administration Purchasing General Accounting Patient Accounts and Inpatient Admitting Insurance-Professional Malpractice Insurance-Hospital Malpractice Insurance-Other Interest-Short Term	Payroll Dollars " " " " " " " " "	Payroll dollars all salaries and wages reported on Schedule IX, Columns 2 and 3, excluding Fringe Benefits (Line 6)
Plant Maintenance and Repairs	Square Feet	Square feet should conform to the AHA guidelines for determining net square feet.
Plant Operations Security Parking Licenses and Taxes (other than Income)	Square Feet " " "	" "
Laundry and Linen	Number of Dry Weight	Record the pounds processed of linen processed (laundered and

		dried) plus the equivalent weight of disposable linen substitutes used.
Housekeeping	Hours of Service	Number of hours spent servicing each department.
Cafeteria	Full-Time Equivalents	FTEs are computed by dividing the total annual hours paid (including (vacation, sick (leave, and over- time) for all employees by 2,080 hours. This should agree with Schedule II, Cols.12 and 13.
Dietary	Number of Meals Served	Count only regularly scheduled meals (3) meal schedules (only) and exclude snacks served between regularly scheduled meals).
Maintenance of Personnel	Average Number Living In	Should be generated from a tally of personnel, by department, who live in hospital facilities. The number should be weighted by the number of days living in to arrive at an average.
Nursing Administration	Nursing Hours	Total the number
InService Education-Nursing	" "	of hours performed by all personnel under the supervision of the Nursing Services Administration.
RN and LPN Education	Assigned Hours	Obtain from curriculum schedules maintained by the School of Nursing.
Medical Staff -	Hours of	Time spent by

Teaching	Student Service	interns and residents in each department.
Medical Staff-Administration	" "	
Post Graduate Medical Education	" "	
Central Service and Supplies	Costed Requisitions	Costed requisitions, charge tickets, floor requisitions, etc. must reflect the cost of the item issued. The costed requisitions are then summarized and charged to departments monthly. Consideration to FIFO, LIFO, moving average, etc., methods should be consistently applied.
	" "	
Pharmacy	" "	
Medical Records	Gross Revenue	Should be allocated on the basis of Gross Revenues in each cost center.
Medical Care Review	Number of Patients	Should be actual reviewed count of patients whose cases are reviewed.
Social Services	Number of Cases	Count each patient whose case is handled as one case.

Schedule XIV - Stepdown Expenses-Excluding Capital

1. On this schedule, the costs, excluding capital, from the non-revenue producing (overhead) departments are stepped down to the ancillary, inpatient, outpatient, and non-patient departments.

2. Direct expense, after adjustments and recoveries, are carried forward to this schedule from:

    a. Schedule IX, Column 13 for Overhead Expenses.

b. Schedule IX, Column 12 for Ancillary, Inpatient Routine, Outpatient Routine, Non-Patient Expenses, Recovery, Provision for Bad Debt and Gross HSN Assessment.

3. Overhead costs are allocated using the statistical bases for stepdown from Schedule XIII. Once a department is stepped down, it is considered to be closed and should receive no subsequent allocations from other cost centers. Allocations will be made only where space is provided. Cost centers closed and xxxxxd out will carry no cost prorations.

4. The mechanical function of cost allocation and stepdown is as follows:

a. The Direct Expense to be Stepped Down from Schedule IX, Column 13 should be entered in Column 2.

b. The costs on Line 2, Column 4 are allocated in Column 6 per the statistical bases on Schedule XIII, Column 6. This is done by first computing a unit cost multiplier on Schedule XIII, Line 102, Column 6 (by dividing the costs in Schedule XIV, Column 4, Line 2 by the statistics to be stepped down on Schedule XIII, Column 6, Line 101). Then the unit cost is multiplied by the statistics on each line on Schedule XIII, Column 6 and the product is recorded on the corresponding line on Schedule XIV, Column 6. The total on Line 100, Column 6 must equal the total expense for stepdown on Line 2, Column 4.

c. The costs allocated on Line 3, Column 6 are added on Line 3, Column 3 and totaled on Line 3, Column 4.

d. The costs on Line 3, Column 4 are allocated in Column 7 per the statistical bases on Schedule XIII, Column 7 and using the unit cost multiplier computed on Schedule XIII, Line 102, Column 7. The total on Line 100, Column 7 must equal the total expense for stepdown on Line 3, Column 4.

e. The costs allocated on Line 4, Column 6 plus the costs allocated on Line 4, Column 7 are added on Line 4, Column 3 and totaled on Line 4, Column 4.

f. The costs on Line 4, Column 4 are allocated in Column 8 per the statistical bases on Schedule XIII, Column 8 and using the unit cost multiplier computed on Schedule XIII, Line 102, Column 8. The total on Line 100, Column 8 must equal the total expense for stepdown on Line 4, Column 4.

g. The costs allocated on Line 5, Column 6 plus Column 7 plus Column 8 are added on Line 5, Column 3 and totaled on Line 5, Column 4.

h. The costs on Line 5, Column 4 are allocated in Column 9 per the statistical bases in Schedule XIII, Column 9 and using the unit cost multiplier computed on Schedule

XIII, Line 102, Column 9. The total on Line 100, Column 9 must equal the total expense for stepdown on Line 5, Column 4.

i. Continue all allocations in the same manner through Line 20.

j. Add Line 22, Columns 6 through 24 to Line 22, Column 2 and total to Line 22, Column 25. Continue in the same manner through Line 98. The total on Line 100, Column 2 (Direct Expense) must equal the total on Line 100, Column 25 (Total Expense after Stepdown).

5. The costs after stepdown in Column 25 are the base for the distribution of Patient Service Expenses on Schedule XVII.

Schedule XV: Stepdown Expenses-Including Capital

1. On this schedule, the costs, including capital, from the overhead departments are stepped down to the ancillary, inpatient, outpatient, and non-patient departments.

2. Direct expenses, after adjustments and recoveries, are carried forward to this schedule from:

   a. Schedule IX, Column 13 for overhead expenses.

   b. Schedule IX, Column 12 for Ancillary, Inpatient Routine, Outpatient Routine, Non-Patient Expenses, Recovery, Provision for Bad Debt and Gross HSN Assessment.

3. Overhead costs are allocated using the statistical bases for stepdown from Schedule XIII. Once a department is stepped down, it is considered to be closed and should receive no subsequent allocations from other cost centers. Allocations will be made only where space is provided. Cost centers closed and xxxxxd out will carry no cost prorations.

4. The mechanical function of cost allocation and stepdown is the same as explained for Schedule XIV, with the addition of the Capital costs, and is as follows:

   a. The Direct Expense to be Stepped Down from Schedule IX, Column 13 should be entered in Column 2.

   b. The costs on Line 1, Column 4 are allocated in Column 5 per the statistical bases on Schedule XIII, Column 5. This is done by first computing a unit cost multiplier on Schedule XIII, Line 103, Column 5 (by dividing the costs in Schedule XV, Column 4, Line 1 by the statistics to be stepped down on Schedule XIII, Column 5, Line 101). Then the unit cost is multiplied by the statistics on each line on Schedule XIII, Column 5 and the product is recorded on the corresponding line on Schedule XV,

Column 5. The total on Line 100, Column 5 must equal the total expense for stepdown on Line 1, Column 4.

c. The costs allocated on Line 2, Column 5 are added on Line 2, Column 3 and totaled on Line 2, Column 4.

d. The costs on Line 2, Column 4 are allocated in Column 6 per the statistical bases on Schedule XIII, Column 6 and using the unit cost multiplier computed on Schedule XIII, Line 103, Column 6. The total on Line 100, Column 6 must equal the total expense for stepdown on Line 2, Column 4.

e. The costs allocated on Line 3, Column 5 plus the costs allocated on Line 3, Column 6 are added on Line 3, Column 3 and totaled on Line 3, Column 4.

f. The costs on Line 3, Column 4 are allocated in Column 7 per the statistical bases on Schedule XIII, Column 7 and using the unit cost multiplier computed on Schedule XIII, Line 103, Column 7. The total on Line 100, Column 7 must equal the total expense for stepdown on Line 3, Column 4.

g. The costs allocated on Line 4, Column 5 plus Column 6 plus Column 7 are added on Line 4, Column 3 and totaled on Line 4, Column 4.

h. The costs on Line 4, Column 4 are allocated in Column 8 per the statistical bases in Schedule XIII, Column 8 and using the unit cost multiplier computed on Schedule XIII, Line 103, Column 8. The total on Line 100, Column 8 must equal the total expense for stepdown on Line 4, Column 4.

i. Continue all allocations in the same manner through Line 20.

j. Add Line 22, Columns 5 through 24 to Line 22, Column 2 and total to Line 22, Column 25. Continue in the same manner through Line 98. The total on Line 100, Column 2 (Direct Expense) must equal the total on Line 100, Column 25 (Total Expense after Stepdown).

5. The costs after stepdown in Column 25 are the base for the distribution of Patient Service Expenses on Schedule XVIII.

Schedule XVI: Patient Service Statistics

1. This schedule shows the distribution of ancillary statistics by inpatient, outpatient, and non-patient services and should correspond to the departments for which data is reported on

Patient Statistics (Schedule III), Payer Information (Schedule VA), Gross Patient Service Revenue (Schedule VI), Stepdown Statistics and Expenses (Schedules XIII, XIV, and XV) and Patient Service Expenses (Schedules XVII, and XVIII).

The patient days as reported on Schedules III, VA and XVI should have corresponding ancillaries reported in cols. 5 through 38 on Schedule XVI. The hospital should not report an aggregate of the ancillaries on line 1 (M&S). For example, if there are patient days reported in col. 3 lines 1 and 2, there should also be ancillaries reported in cols. 5 through 38 for lines 1 and 2.

2. Statistics must be reported on the basis specified for each department. Variations and alternative methods will not be accepted unless prior approval, in writing, is obtained from CHIA. Existing columns and lines must NOT be altered. Several blank lines are provided in each of the following sections: Routine Acute, Routine ICU and Outpatient. These lines will be used to report services that are not specified in each section. Use a separate line for each added service in the appropriate section. There are (5) five additional columns for the Ancillary for any added services. These columns will be used to report ancillaries not already specified. Use a separate column for each added ancillary. If more than the available blank lines and/or columns are needed in any particular section submit a supplementary schedule in the same format as Schedule XVI. All lines and columns, including subtotals and totals must be completed. If the hospital files a supplemental schedule, transfer the total of the lines and/ or columns to the first blank line and/ or column on schedule XVI in the appropriate section.

3. All statistics must be accumulated for a twelve (**12**) month period which must coincide with the financial reporting year.

4. All statistics must be reported in each column for all relevant inpatient, outpatient, and non-patient services.

   Note: For Observation Beds with a distinct unit, report all relevant statistics on the designated line (line 31).
   For Observation Beds without a distinct unit, expenses will be allocated on schedules XVIIA and XVIIIA. Therefore, **do not report ancillary statistics on columns 5 through 38, line 31.** These statistics should be reported in the departments where the patients were originally treated. However, enter the number of visits on column 3, line 31.

5. In order to allocate costs on the Patient Service Expense Schedules (XVII and XVIII), a unit cost multiplier must be calculated on Line 45 (excluding capital) and Line 46 (including capital).

The unit cost multiplier excluding capital (Line 45) is calculated by dividing the costs after stepdown, (Schedule XIV, Column 25, Lines 22 through 55) by the total statistics (Schedule XVI, Line 42, Columns 5 through 38).

For example, to compute the surgery unit cost multiplier on Line 45, Column 5, divide surgery total expenses after stepdown (Schedule XIV, Column 25, Line 22) by total surgery minutes (Schedule XVI, Column 5, Line 42). Continue in the same manner for Columns 6 through 38.

Calculate the unit cost multipliers including capital (Schedule XVI, Line 46, Columns 5 through 38 in the same manner, using Total Expense after Stepdown from Schedule XV, Column 25, Lines 22 through 55.

6. For a complete description of the required statistics, refer to the Hospital Uniform Reporting Manual. The statistics are listed below:

Department	Statistics
Surgery	Surgery Minutes
Labor and Delivery	Procedures and Weighted Circumcisions
Recovery Room	Recovery Room Minutes
Anesthesiology	Anesthesiology Minutes
IV Therapy	IV Bags Used
Medical Supplies - Special	Costed Requisitions
Drugs - Special	Costed Requisitions
Laboratory	Tests
Blood	Units
Blood Proc. and Storage	Units
EKG	Tests
Cardiac Catheterization	Procedures
Diagnostic Radiology	Tests
Therapeutic Radiology	Visits
CT Scanner	Patients Scanned
Nuclear Medicine	Tests
Respiratory Therapy	Treatments
Pulmonary Function	Tests
EEG	Tests
Electromyography	Tests
Physical Therapy	Treatments
Occupational Therapy	Treatments

Speech-Language Therapy	Sessions
Recreational Therapy	Treatments
Audiology	Procedures
Psychology/Psychiatry	Treatments
Renal Dialysis	Treatments
Organ Acquisition	Organs
Ambulance	Occasions of Service
Emergency Room	Visits
Clinic	Visits
Satellite Clinic (including Community Health Service)	Visits
Ambulatory Surgical Services	Visits
Ambulatory Renal Dialysis	Treatments
Home Dialysis Services	Treatments
Psychiatry	Visits
Home Health Services	Visits
Observation Beds (Distinct or NonDistinct unit)	Visits
Private Referrals	Visits

Surgery Minutes is the difference between starting time and ending time defined as follows:

> Starting time begins with the administration of the anesthetic agent in the operating room (or the beginning of surgery if anesthesia is not administered or if anesthesia is administered in other than the operating room). Ending time is when the anesthetic procedure terminates in the operating room (or the end of surgery if anesthesia is not administered). The time the anesthesiologist spends with the patient in the recovery room is not to be counted. The number of surgery minutes shall be the actual count obtained from the surgical suite operating log.

Number of Procedures and Weighted Circumcisions Report multiple births as one procedure. Include Cesarean sections only when they are performed in the delivery room. One Cesarean should be counted as three deliveries. Still-births are counted as procedures. Cesarean sections performed in the surgical suite shall be included in the operating room statistics and infants born outside the hospital building are not to be classified as a procedure. Whenever gynecological procedures such as abortions, D and C's, etc., are performed in Labor and Delivery, each procedure performed is counted as one. Seven circumcisions are to be classified as one delivery if performed in the delivery suite. The number of procedures shall be an actual count.

Recovery Room Minutes is the difference between the time of admission to the recovery room and the time of discharge from the unit. The number of Recovery Room minutes shall be an actual count.

Anesthesia Minutes are defined as the difference between the starting time and the ending time defined as follows:

> Starting time begins with the administration of the anesthetic agent in the operating room. Ending time is when the anesthetic procedure terminates in the operating or delivery room. The time the anesthesiologist spends with the patient in the recovery room is not to be counted. The number of anesthesia minutes shall be the actual count.

Number of I.V. Bags Used Count each I.V. Bag used as one. The number of I.V. bags shall be obtained from an actual count.

Costed Requisitions Costed requisitions, charge tickets, floor requisitions, etc., must reflect the cost of the item issued. The costed requisitions are then summarized and charged to departments monthly. Consideration to FIFO, LIFO, moving average, etc., should be consistently applied.

Cardiac Catheterization Procedures Count each cardiac catheterization procedure for which a charge is made as one procedure. The number of procedures shall be an actual count.

Number of Patients Scanned A scan is a per patient procedure which may consist of a routine or a multiple scan. A routine scan is a scan or any number of scanning slices with or without contrast. A multiple scan is a procedure consisting of a routine scan or any number of slices without contrast followed by a scan or any number of slices with contrast. The number of scans shall be the actual count.

Respiratory Therapy Treatments Count each procedure for which a charge is made as one treatment. Oxygen charges would be reported as one per day regardless of service time. All-inclusive rate hospitals should count treatments as if a charge were to be made. The number of treatments shall be an actual count.

Physical Therapy Treatments Count each procedure for which a separate charge is made as one treatment. Physical therapy charges would be reported as one per day regardless of service time. The number of treatments shall be obtained from an actual count.

Occupational Therapy Treatments Count each procedure as one treatment. In group sessions, the number of treatments would be equal to the number of patients in the group. Count only those procedures which are charged for. The number of treatments shall be an actual count.

Speech-Language Therapy Sessions Count each evaluation and each treatment session for which there is a charge as one session. For group activities, count as one session each patient participating in the session. The number of sessions shall be an actual count.

Recreational Therapy Treatments Count each procedure for which a separate charge is made as one treatment. The number of treatments shall be an actual count.

Audiology Procedures Count each procedure for which a charge is made as one procedure.

Psychology Treatments Count each procedure for which a separate charge is made as one treatment or session. The number of treatments shall be an actual count.

Renal Dialysis Treatments Count each treatment for which a separate charge is made as one treatment regardless of the length of the treatment. The number of treatments shall be an actual count.

Organs Count each organ acquired as one. The number of kidney, liver, and heart acquired shall be an actual count.

Occasions of Service Ambulance service provided to a patient is counted as one occasion of service regardless of special services rendered at the point of pickup or during transport. For example, the administration of oxygen and first aid during the pick-up and delivery of the patient would not be counted as a separate occasion of service. The number of occasions of service shall be the actual count.

Visits A visit is defined as each registration of a patient in a formally organized clinic of the hospital. Multiple services performed in one clinic on the same day constitute one visit. (Multiple services can be encounters with two or more clinicians, two or more occasions of service on the same day, or any combination of encounters and occasions of service on the same day.)

Visits to more than one formally organized clinic on the same day should be counted separately. For example, services provided at ENT and Orthopedics on the same day should be recorded as 2 visits.

Recording statistics for ancillary services depends upon whether the patient has registered in an outpatient clinic of the hospital.

- Ancillary services provided to a patient during an outpatient clinic, ER, Ambulatory Surgery, or Other clinic visit should not be recorded as a visit, however, ancillary statistics should be recorded.

- Ancillary services provided to patients who are **Private Referrals** and are not registered in an Outpatient Clinic, ER, Ambulatory Surgery, or Other Clinic should not be recorded as a visit, however, the ancillary statistics should be recorded.

Most importantly, the number of lab tests performed or number of treatments or minutes of service may NOT be substituted for the number of visits.

Schedule XVII: Patient Service Expenses-Excluding Capital

1. This schedule shows the distribution of Total Expenses excluding capital after Stepdown (Schedule XIV, Column 25) by Inpatient, Outpatient, and Non-Patient services.

2. Allocate costs to each inpatient, outpatient, and non-patient service by multiplying the statistics on Schedule XVI, Columns 5 through 38 by the unit cost multiplier on Schedule XVI, Line 45, Columns 5 through 38. For example, surgery costs in the Medical and Surgical Acute Inpatient Service (Schedule XVII, Column 5, Line 1) is the product of surgery minutes (Schedule XVI, Column 5, Line 1) times the surgery unit cost multiplier (Schedule XVI, Column 5, Line 45).

3. Since capital costs are excluded from the cost distribution on this schedule, the calculation of a loading factor is required in order to compute capital costs. The loading factor allocates capital costs on the basis of a ratio of patient care costs to non-patient care costs, rather than on the statistical basis of square feet.

    a. Subtotal Capital and Long-Term Interest on Schedule IX, Column 12, Line 1+2+3+4 are carried forward to Column 2, Line 49.

    b. Divide Capital and Long-Term Interest cost by the Total Operating Costs excluding capital (Schedule XVII, Column 2, Line 42 to develop a capital to non-capital cost ratio) (the loading factor).

    c. Capital costs can be allocated between patient related and non-patient related costs by multiplying the loading factor by:

        i) Inpatient and Ambulatory Care Costs (Schedule XVII, Line 37, Column 2) to determine patient related capital costs; and

        ii) Non Patient costs (Schedule XVII, Line 41, Column 2) to determine non-patient related capital costs.

4. The Total on Line 42 for Columns 5 through 38 must agree with Schedule XIV, Column 25, Lines 22 through 55.

Schedule XVIIA: Routine Inpatient Expenses Net of NonDistinct Unit Observation Beds Expenses-Excluding Capital

The purpose of this schedule is to determine the expenses for acute care services net of observation beds expenses. It should be used only for hospitals, which do not have a distinct unit for Observation Beds.

Line A	Column 1 Routine Amount:	Total expenses for acute care services-routine, excluding capital are posted from Schedule XVII, column 3, line 10.
Line A	Column 2 Ancillary Amount:	Total expenses for acute care services-ancillary, excluding capital are posted from Schedule XVII, column 4, line 10.
Line A	Column 3 Total Expenses:	Total Expense-Sum columns 1 and 2. This amount must agree with Schedule XVII column 2, line 10.
Line B	Column 1 Routine Amount:	Enter Skilled Nursing Facilities expenses from Schedule XVII, column 3, line 6.
Line B	Column 2 Ancillary Amount:	Enter Skilled Nursing Facilities expenses from Schedule XVII, column 4, line 6.
Line B	Column 3 Total Expenses:	Total Expense-Sum columns 1 and 2. This amount must agree with Schedule XVII column 2, line 6.
Line C	Columns 1 & 2 :	Line A minus line B.
Line C	Column 3 Total Expenses:	Total Expense-Sum columns 1 and 2.
Line D	Columns 1 & 2:	The ratio of Equivalent Observation Beds Days is posted from Schedule IIIB, column 3, line 7.
Line D	Column 3	Non input line.
Line E	Columns 1 & 2:	Observation Beds Expenses-are apportioned by multiplying line C by line D.
Line E	Column 3 Total Expenses:	Total Expense-Sum columns 1 and 2.
Line F	Columns 1 & 2:	Expenses Net of Observation Beds Expenses-Line A minus Line E.
Line F	Column 3 Total Expenses:	Total Expense-Sum columns 1 and 2.

Column 5 Expenses for acute care services routine, excluding capital are posted from Schedule XVII, Column 3.

Column 6 Expenses for acute care services ancillaries, excluding capital are posted from Schedule XVII, Column 4.

Column 7 Number of Routine Inpatient Days is posted from Schedule III, Column 6, except Skilled Nursing Facilities Days.

Column 8 The ratio of Inpatient Days of each department is computed by dividing each line of column 7 over line 10 of column 7. The total in column 8, line 10 must equal 100%.

Column 9 Total Observation Beds Routine Expenses are then allocated to each department by multiplying each line of column 8 by line E, column 1. Line 10 must agree with line E, column 1.

Column 10 Total Observation Beds Ancillary Expenses are then allocated to each department by multiplying each line of column 8 by line E column 2. Line 10 must agree with line E, column 2.

Column 11 Total Routine Expenses Net of Observation Beds Expenses-Subtract column 9 from column 5 for each department. Line 10 must agree with line F, column 1.

Column 12 Total Ancillary Expenses Net of Observation Beds Expenses-Subtract column 10 from column 6 for each department. Line 10 must agree with line F, column 2.

Column 13 Total Expenses Net of Observation Beds Expenses- Sum Columns 11 & 12 for each department.

Schedule XVIII: Patient Service Expenses-Including Capital

1. This schedule shows the distribution of Total Expenses including Capital after stepdown (Schedule XV, Column 25) by Inpatient, Outpatient, and Non-Patient services.

2. Allocate costs to each inpatient, outpatient, and non-patient service by multiplying the statistics on Schedule XVI, Columns 5 through 38, by the unit cost multiplier on Schedule XVI, Line 46, Columns 5 through 38. For example, surgery costs in the Medical and Surgical Acute Inpatient Service (Schedule XVIII, Column 5, Line 1) is the product of surgery minutes (Schedule XVI, Column 5, Line 1) times the surgery unit cost multiplier (Schedule XVI, Column 5, Line 46).

3. The Total on Line 42 for Columns 5 through 38 must agree with Schedule XV, Column 25, Lines 22 through 55.

Schedule XVIIIA: Routine Inpatient Expenses Net of NonDistinct Unit Observation Beds Expenses-Including Capital

The purpose of this schedule is to determine the expenses for acute care services net of observation beds expenses. It should be used only for hospitals, which do not have a distinct unit for Observation Beds.

Line A	Column 1 Routine Amount:	Total expenses for acute care services-routine, including capital are posted from Schedule XVIII, column 3, line 10.
Line A	Column 2 Ancillary Amount:	Total expenses for acute care services-ancillary, including capital are posted from Schedule XVIII, column 4, line 10.
Line A	Column 3 Total Expenses:	Total Expense-Sum columns 1 and 2. This amount must agree with Schedule XVIII column 2, line 10.
Line B	Column 1 Routine Amount:	Enter Skilled Nursing Facilities expenses from Schedule XVIII, column 3, line 6.
Line B	Column 2 Ancillary Amount:	Enter Skilled Nursing Facilities expenses from Schedule XVIII, column 4, line 6.
Line B	Column 3 Total Expenses:	Total Expense-Sum columns 1 and 2. This amount must agree with Schedule XVIII column 2, line 6.
Line C	Columns 1 & 2 :	Line A minus line B.
Line C	Column 3 Total Expenses:	Total Expense-Sum columns 1 and 2.
Line D	Columns 1 & 2:	The ratio of Equivalent Observation Beds Days is posted from Schedule IIIB, column 3, line 7.
Line D	Column 3	Non input line.

Line E	Columns 1 & 2:	Observation Beds Expenses- are apportioned by multiplying line C by line D.
Line E	Column 3 Total Expenses:	Total Expense-Sum columns 1 and 2.
Line F	Columns 1 & 2:	Expenses Net of Observation Beds Expenses Line A minus Line E.
Line F	Column 3 Total Expenses:	Total Expense-Sum columns 1 and 2.

Column 5 Expenses for acute care services routine, including capital are posted from Schedule XVIII, Column 3.

Column 6 Expenses for acute care services ancillaries, including capital are posted from Schedule XVIII, Column 4.

Column 7 Number of Routine Inpatient Days is posted from Schedule III, Column 6, except Skilled Nursing Facilities Days.

Column 8 The ratio of Inpatient Days of each department is computed by dividing each line of column 7 over line 10 of column 7. The total in column 8, line 10 must equal 100%.

Column 9 Total Observation Beds Routine Expenses are then allocated to each department by multiplying each line of column 8 by line E column 1. Line 10 must agree with line E, column 1.

Column 10 Total Observation Beds Ancillary Expenses are then allocated to each department by multiplying each line of column 8 by line E column 2. Line 10 must agree with line E, column 2.

Column 11 Total Routine Expenses Net of Observation Beds Expenses-Subtract column 9 from column 5 for each department. Line 10 must agree with line F column 1.

Column 12 Total Ancillary Expenses Net of Observation Beds Expenses-Subtract column 10 from column 6 for each department. Line 10 must agree with line F column 2.

Column 13 Total Expenses Net of Observation Beds Expenses-Sum Columns 11 & 12 for each department.

Schedule XXIII: Financial Statements

Balance Sheet

Statements of Operations
Statements of Changes in Net Assets
Statements of Cash Flow

For Non-Acute hospitals only: These statements must be prepared in accordance with the **American Institute of Certified Public Accountants Audit of Providers of Health Care Services, Audit and Accounting Guide and modified by the format of Schedules XXIII.** Audited Financial Statements will **not** be accepted in lieu of Schedule XXIII. Variations in the data between Schedule XXIII and the Audited Financial Statement must be accompanied by a reconciliation.

GENERAL INSTRUCTIONS

1. Round all dollar amounts to the nearest thousand.

2. Unless otherwise indicated, the format should be fixed with no decimal places and no commas or other non-numeric indicators.

ROW	VARIABLE	DESCRIPTION AND CODING INSTRUCTIONS
1	Hospital Name	Enter name
2	CPA Name	From audited financial statements, use the initial eight letters of the name of the firm preparing the statements. Example: Coopers
3	Fiscal Year	Enter year
4	Balance Sheet	Heading - non input
5	Current Assets	Heading - non input
6	Cash and Cash Equivalents	Cash and Cash Equivalents
7	Short-term Investments	Short-term investments listed under current assets.
8	Current Assets - Whose Use is Limited	Any current portion of assets whose use is limited, either identified as board-designated, trustee-held, and other designations.

9	Receivables	Heading - non input
10	Net Patient Accounts Receivable	Patient accounts receivable, minus allowances for contractual adjustments, bad debt, and free care.
11	Due From Affiliates	Includes receivable from affiliated entities reported as current. Enter 0 if no value.
12	Third Party Settlements Receivable	Includes amounts reported as current that represent final settlements due to the hospital. Enter 0 if no value.
13	Other Accounts Receivable	Includes other receivables not related to patient services, third party receivables or affiliates. Enter 0 if no value.
14	Inventory	Leave blank if no value or combined with other assets.
15	Other Current Assets	All other current assets including prepaid expenses, deposits, and amounts due from restricted funds. Enter 0 if no value.
16	Total Current Assets	Total of rows 6 through 15.
17	NonCurrent Assets	Heading - non input
18	NonCurrent Assets - Whose Use is Limited	Any non-current portion of asset whose use is limited, either identified as board-designated, trustee-held, and other designations.
19	Receivable from Donors/ Grantors for Specific Purpose	Include all receivable restricted for specific purpose by donors/grantors.
20	Permanently Restricted Funds	Include all permanently restricted funds.
21	Due From Affiliates	Includes notes receivable from affiliates which have been classified as non-current.
22	Investments In	Amount recorded as equity investments in

		Affiliates other entities, which are related to the hospital.
23	Undesignated NonCurrent Investments	All undesignated, unrestricted non-current investments except as itemized elsewhere in these instructions.
24	Other NonCurrent Assets	All other non-current investments not listed above. Amounts due from restricted funds, deposits, other non-current receivables, rental property, deferred financing costs, and deferred charges.
25	Gross Property, Plant and Equipment	Gross value of land, buildings, equipment, construction in progress, and capitalized leases.
26	Accumulated Depreciation	Includes depreciation of PP&E and amortization of capitalized leases.
27	Net PP&E	Row 25 minus row 26.
28	Total NonCurrent Assets	Sum of rows 18 through 24 plus 27.
29	Total Assets	Sum of rows 16 and 28.
30	Liabilities and Net Assets	Heading - non input
31	Current Liabilities	Heading - non input
32	Current Long-Term Debt	Current portion of long-term debt and capital leases. Do not include notes payable. Enter 0 if no value.
33	Accounts Payable and Accrued Expenses	Includes accounts payable, accrued salaries, wages, payroll taxes, vacation, other accrued liabilities, and the current portion of accrued pension costs and post-retirement benefit costs. Enter 0 if no value.

34	Current Liability Estimated Third Party Settlements	Amounts received from third parties which may be in excess of allowable amounts and may therefore be paid back to third parties or else resolved favorably and recognized as revenue in the future. Also the current portion of deferred revenue.
35	Current Liability Due To Affiliates	Current amounts due to related entities.
36	Other Current Liabilities	All other current liabilities including amounts due to other funds, notes payable, and the current portion of any self-insurance funds and post-retirement health benefits.
37	Total Current Liabilities	The total of rows 32 through 36.
38	NonCurrent Liabilities	Heading - non input
39	Long-Term Debt	Includes long-term debt (do not include current portion), obligations under capital leases, and mortgage notes payable. Enter 0 if no value.
40	Self-Insurance Fund	Includes self-insurance, reserve for professional liability, and workers' compensation. Any portion of a self-insurance fund which is not listed with current liabilities should be placed here. Enter 0 if no value.
41	NonCurrent Liability Estimated-Third Party Settlements	NonCurrent amounts received from third parties that may be in excess of allowable amounts and may therefore be paid back to third parties or else resolved favorably and recognized as revenue in the future. Also, deferred revenues, which have been received from third parties, but not yet recognized through charge reductions. (NonCurrent portion of row 34).

42	NonCurrent Liability Due to Affiliates	NonCurrent amounts due to related parties. (NonCurrent portion of row 35)
43	Accrued Pension and Post-Retirement Health	NonCurrent amounts of accrued pension and post-retirement health benefits. (Current portion of the Benefits are included in line 36)
44	Other NonCurrent Liabilities	All other non-current liabilities including deferred credits & gains and non-current payable.
45	Total NonCurrent Liabilities	Total of rows 39 through 44.
46	Total Liabilities	Total of 37 and 45.
47	Net Assets	Heading - non input
48	Unrestricted	Includes the part of net assets that are neither temporarily restricted nor permanently restricted by donor/grantor stipulations.
49	Temporarily Restricted	Includes the part of net assets temporarily restricted by donor/grantor stipulations.
50	Permanently Restricted	Includes the part of net assets permanently restricted by donor/grantor stipulations.
51	Total Net Assets	Sum rows 48 through 50.
52	Total Liabilities and Net Assets	The sum of rows 46 and 51.
53	Statements of Operations	Heading - non input
54	Unrestricted Revenue Gains and Other Support	Heading - non input
55	Net Patient Service Revenue	Total inpatient and outpatient revenue after deductions for free care and con-

		tractual adjustments. Prior year third party settlements, gross receipts for emergency bad debts and free care costs expected to be recovered from the pool should also be included in net revenue.
56	Premium Revenue	Include all premium recognized as revenue during the period in which the HMO is obligated to provide services to members. If none, enter 0.
57	Other Revenue	Include any other revenue which is not classified elsewhere. Examples include: Garage Revenue, Cafeteria Revenue, Rental Income, and other Non Patient sources.
58	Investment Income	All investment income (e.g. interest income).
59	NonOperating Gains(Losses)	Include all non-operating gains (losses) not restricted.
60	Net Assets Released from Restrictions Used for Operations	Heading - non input
61	Satisfaction of Program Restrictions	Include all restricted fund released due to the satisfaction of program restrictions. If none, enter 0.
62	Satisfaction of Equipment Restrictions	Include all restricted fund released due to the satisfaction of equipment restrictions. If none, enter 0.
63	Expiration of Time Restrictions	Include all restricted fund released due to the expiration of time. If none, enter 0.
64	Other Restricted Assets Released for Operations	Include all other restricted revenue not enter on rows 61 through 63. If none, enter 0.
65	Total Unrestricted Revenue Gains and Other Support	Sum rows 55 through 59 plus 61 through 64.

66	Expenses	Heading - non input
67	Depreciation	If depreciation and amortization are reported separately, put the depreciation expense here and do not input in row 68. If they cannot be separated, put the total amount in row 68 and do not input in this row.
68	Depreciation and Amortization	See row 67.
69	Interest	Includes all Interest Expense.
70	Gross HSN Assessment	This includes Gross Payments to HSN.
71	Provision for Bad Debt	Allowances for uncollectible and doubtful accounts.
72	Other Expenses	All other expenses not reported in rows 67 through 71.
73	Total Expenses	Total of rows 67 through 72.
74	Excess of Revenue, Gains and Other Support Over Expenses	Row 65 minus row 73.
75	Changes in net unrealized gains and losses on investments securities other than trading securities	Include the net change in unrealized gains/ losses on investments other than trading between current year and prior year.
76	Net assets released from restrictions for purchase of property and equipment	Include the net assets released from restrictions for purchase of property and equipment.
77	Contribution from hospital foundation for property acquisitions	Include contribution for property acquisitions from hospital foundation. If none, enter 0.
78	Transfers from (to) parent	Include all fund transfers from (to) parent.

		If none, enter 0.
79	Increase in unrestricted net assets, before extraordinary item	Sum rows 74 through 78.
80	Extraordinary Gains (Losses) from Extinguishment of Debt	Any extraordinary gains (losses) from refunding of debt, tax carry-forward, etc.
81	Changes in Accounting Principle/Other	Any other gains (losses) such as amount resulting from changes in accounting practices.
82	Increase in Unrestricted Net Assets	Sum rows 79 through 81.
83	Statements of Changes in Net Assets	Heading - non input
84	Unrestricted Net Assets	Heading - non input
85	Excess of Revenue, Gains and Other Support Over Expenses	Row 74
86	Changes in net unrealized gains and losses on investment securities other than trading securities	Row 75
87	Net Assets released from restrictions for purchase of property and equipment	Row 76
88	Contribution from hospital foundation for property acquisitions	Row 77
89	Transfers from (to) parent	Row 78
90	Increase in unrestricted net assets, before extraordinary item	Sum of rows 85 through 89.

91	Extraordinary Gains (Losses) from Extinguishment of Debt	Row 80
92	Changes in Accounting Principle/Other	Row 81
93	Increase in Unrestricted Net Assets	Sum rows 90 through 92.
94	Temporarily Restricted Net Assets	Heading - non input
95	Contribution for Charity Care	Include all contribution temporarily restricted by donor/grantor stipulations for charity care.
96	Net realized and unrealized gains on investments	Include net realized and unrealized gains on temporarily restricted investments.
97	Net assets released from restrictions	Include the net assets released from restrictions.
98	Increase (decrease) in temporarily restricted net assets	Sum rows 95 through 97.
99	Permanently restricted net assets	Heading - non input
100	Contributions for endowment funds	Include all contributions for endowment permanently restricted.
101	Net realized and unrealized gains on investments	Include net realized and unrealized gains on permanently restricted investments.
102	Increase in permanently restricted net assets	Sum rows 100 through 101.
103	Increase (decrease) in net assets	Sum rows 93, 98, and 102.
104	Net assets at beginning of year	Value from row 105 from the prior year.
105	Net assets at end of year	Sum rows 103 and 104.

106	Statements of Cash Flows	Heading - non input
107	Cash Generated from Operating Activities	Heading - non input
108	Change in net assets (deficit)	Value from row 103.
109	Adjustments to reconcile change in net assets to net cash provided by operating activities	Heading - non input
110	Extraordinary (Gains)/ Losses	Value with opposite sign from row 80.
111	Changes in Accounting Principles and Other (Gains)/ Losses	Value with opposite sign from row 81.
112	Depreciation and Amortization	Include sum of values from rows 67 & 68.
113	Net unrealized gains and losses on investments other than trading	Value with opposite sign from row 86.
114	Transfers from (to) parent	Include opposite value from row 78.
115	Provision for Bad Debt	Include value from row 71.
116	Restricted Contributions and Investments Income Received	Include opposite value from row 102.
117	(Increase) Decrease in	Heading-non input
118	Current Assets Whose Use is Limited	Change from the previous year in row 8.
119	Accounts Receivable	Changes from the previous year in net patient accounts receivable (row 10) and in other accounts receivable (row 13).

120	Due from Affiliates	Change from the previous year in row 11.
121	Third Party Settlements Receivable - Current	Change from the previous year in row 12.
122	Inventory	Change from the previous year in row 14.
123	Other Current Assets	Change from the previous year in row 15.
124	Increase (decrease) in	Heading-non input
125	Accounts Payable and Accrued Expenses	Change from the previous year in row 33.
126	Current Estimated Third Party Settlements	Change from the previous year in row 34.
127	Due to Affiliates	Change from the previous year in row 35.
128	Other Current Liabilities	Change from the previous year in row 36.
129	Self-Insurance Fund NonCurrent	Change from the previous year in row 40.
130	Third Party Settlements NonCurrent	Change from the previous year in row 41.
131	Due to Affiliates NonCurrent	Change from the previous year in row 42.
132	Accrued Pension and Post Retirement Health Benefits	Change from the previous year in row 43.
133	Trading	Gains(losses) from trading of securities.
134	Other (specify)	Other current and non-current changes in assets and liabilities from previous year.
135	Other (specify)	Other current and non-current changes in assets and liabilities from previous year.

136	Other (specify)	Other current and non-current changes in assets and liabilities from previous year.
137	Other (specify)	Other current and non-current changes in assets and liabilities from previous year.
138	Other (specify)	Other current and non-current changes in assets and liabilities from previous year.
139	Net Cash Provided by Operating Activities	Sum of rows 108 through 138.
140	Cash Flows from Investing Activities	Heading - do not code.
141	NonCurrent Assets Whose Use is Limited	Change from the previous year in row 18.
142	NonCurrent Assets Due from Affiliates	Change from the previous year in row 21.
143	Investments in Affiliates	Change from the previous year in row 22.
144	Undesignated NonCurrent Investments	Change from the previous year in row 23.
145	Other NonCurrent Assets	Change from the previous year in row 24.
146	Capital Expenditures	Includes purchase of property, plant, and equipment.
147	Sale of Fixed Assets	Includes cash proceeds from sale of property, plant, equipment, and other fixed assets.
148	Other (specify)	Other current and non-current changes in assets as a result of investing activities.
149	Other (specify)	Other current and non-current changes in assets as a result of investing activities.

150	Other (specify)	Other current and non-current changes in assets as a result of investing activities.
151	Other (specify)	Other current and non-current changes in assets as a result of investing activities.
152	Other (specify)	Other current and non-current changes in assets as a result of investing activities.
153	Net Cash Used in Investing Activities	Sum of rows 141 through 152.
154	Cash Flows from Financing Activities	Heading - do not code.
155	Proceeds from Issuance of Long-Term Debt and Capital Lease Obligations	Includes cash from long-term debt and capital leases. Also includes bond issuance costs.
156	Payments on Long-Term Debt (Include Current LTD) and Capital Lease Obligations	Includes repayment of long-term debt and capital leases. Also add in the change in the current maturities of long-term debt.
157	Other NonCurrent Liabilities	Change from the previous year in row 44.
158	Transfers from (to) parent	Value with opposite sign from row 114.
159	Proceeds from Restricted Contributions and Restricted Investments Income	Value with opposite sign from row 116.
160	Other (specify)	Other current and non-current liabilities as a result of financing activities.
161	Other (specify)	Other current and non-current liabilities as a result of financing activities.
162	Other (specify)	Other current and non-current liabilities as a result of financing activities.
163	Other (specify)	Other current and non-current liabilities as a result of financing activities.

164	Other (specify)	Other current and non-current liabilities as a result of financing activities.
165	Net Cash Used in Financing Activities	Sum of rows 155 through 164.
166	Net (Decrease) Increase in Cash and Cash Equivalent	Sum of rows 139, 153, and 165. To verify the accurate completion of NetCash Flow Statement, the value for row 166 should agree with the net change in rows 6 & 7 from the previous year.
167	Cash and Cash Equivalents, Beginning of Year	Value from line 168 for the prior year.
168	Cash and Cash Equivalents, End of Year	Sum of rows 166 & 167.
169	Supplemental Disclosures of Cash Flow Information	Heading - do not code.
170	Other Significant Transaction not Affecting Cash	Heading - do not code.
171	Transfer of Assets From (to) Affiliates	Includes transfers of non-cash assets (e.g. PP&E) from (to) affiliates and other entities.
172	Other NonCash (Specify)	Includes changes in other non-cash items, such as donation of property.

Lines 173 and beyond are ratios, which will be automatically computed after the completion of the financial statements.

Schedule XXV: Physician Compensation

1. This schedule is a summary of all physicians' compensation regardless of whether they are salaried or contracted. It disaggregates direct compensation into three parts, column 3 - professional fees; column 4 - cost center supervision, and column 5 - other direct expenses

There are at least five general types of financial arrangements between hospitals and hospital based physicians:

- **Agency Arrangement:** The hospital bills patients for the physician's professional services, but records these billings as liabilities and the subsequent payment to the physician as a reduction of that liability. The hospital reflects no operating revenue or expense relative to the professional component.

- **Compensation Arrangements:** The hospital bills patients for physicians' contractual professional services, including this amount as hospital revenue. All cost center expenses are paid by the hospital. The hospital remits a fee or pays a salary to the physician, which is included in hospital expenses.

  The compensation arrangement can be either fixed or variable. Under a fixed compensation arrangement, the physician is paid a specific dollar amount (salary) unrelated to volume of services rendered. Under the variable compensation arrangement, the physician's compensation will be a percentage of departmental gross charges or net collections. The actual compensation received by the physician will vary in proportion to the number of procedures performed and to the total charges made by the hospitals.

- **Contracted Arrangements:** Under this arrangement, the physician may pay any or all expenses of the cost center. The hospital bills patients for the departmental services and remits a fee to the physician. This fee would typically be designed to cover the expenses incurred by the physician plus his professional fee. **Payments to the Physician are recorded as Professional Fees.**

- **Rental Agreement:** The physician bills the patients for certain parts of the Part A and Part B component (as defined by Medicare) and incurs all substantial direct expenses. The physician remits a fee to cover certain hospital expenses. This fee is recorded as operating revenue in the appropriate revenue center.

- **Independent/Separate Arrangement:** The functions are provided by an independent physician or group of physicians. Neither revenues nor expenses are incurred by the hospital. The hospital refers patients and/or specimens to the physician or group, which is usually located on separate premises. No costs are incurred and no revenue is received under this arrangement.

  The services provided by hospital-based physicians may be categorized into six general types:

- **Professional Component:** Providing direct patient care.

- **Education:** Teaching and supervising student activity in educational programs.

- **Research:** Working on research project.
- **Medical Care Review:** Serving on the hospital's Medical Care Review Committee.
- **Medical Staff Administration:** Administering overall medical staff activities.
- **Cost Center Supervision:** Supervising activities of the cost center.

When physicians are involved in more than one of the above functional activities, their remuneration, if any, must be recorded in the Cost Center for which services are performed. Prior to reporting remuneration of the Direct Expense Schedule, the remuneration must be classified in the appropriate Cost Centers.

For example, if a physician is paid and spends 40% of his time in direct care of patients, 10% in educational activities, 15% in research, 5% in medical care review activities, 10% in administrative duties outside the department, and 20% in supervision of the department, the reclassification of this remuneration would be as follows:

40% Physician's Professional Component (This amount remains in the Department Cost Center).

10% Education Cost (This amount must be reported in the Medical Staff - Teaching Cost Center).

15% Research Projects (This amount must be reported in the Non Patient Research Cost Center).

5% Medical Care Review (This amount must be reported in the Medical Care Review Cost Center).

10% Hospital Administration (This amount must be reported in the Medical Staff Administration Cost Center)

20% Cost Center Supervision (This amount remains in the Department Cost Center).

Computation: If the above physician is paid $50,000 annually, including employee benefits, the following reclassification would be required for reporting purposes:

Professional Component (col. 3): 40% of 50,000 = $20,000

Education (col. 5): 10% of $50,000 = $5,000

Research (col. 5): 15% of $50,000 = $7,000

Medical Care Review (col. 5): 5% of $50,000 = $2,500

Administration (col. 5): 10% of $50,000 = $5,000

Cost Center Supervision (col. 4): 20% of $50,000 = $10,000

The financial arrangement for non-hospital based physicians should be reported on Schedule XXV, column 3, professional fees. These physicians are not part of the hospital staff and do not have admitting privileges. They provide a service, which requires an expertise that is not ordinarily provided by the hospital.

For example: a non-hospital based Radiologist who is specifically contracted by the hospital to provide the service of reading a specialized nuclear scan.

2. Physician Compensation, column 2, is the sum of column 3, Professional fees; column 4 - Cost center supervision and column 5 - Other direct.

3. Professional Fees, column 3, is remuneration for direct patient care.

4. Cost center supervision, column 4, is remuneration for supervising activities of the cost center.

5. Other direct, column 5, includes the direct costs for medical staff teaching, medical staff-administration, post graduate education, medical care review, research and non-patient activities.

6. Total Physician Compensation, column 2, the sum of column 2, Physician Compensation, of Schedule XXV should be transferred to Schedule IX, column 3,Physician Compensation.

Schedule XXVI - Certification Statement

This schedule must be completed. Either the hospital's Chief Executive Officer or Chief Financial Officer must sign it.

Schedule XXVII – Hospital Supplemental Cost Reporting

UNIFORM HOSPITAL COSTS

In Column 3, enter the total cost for the following items, which, where appropriate, must tie to other sections of the DHCFP-403:

Line 1-6 Academic Costs. The costs associated with administering overall medical staff activities (medical staff – admin); the costs of teaching interns and residents (medical staff – teaching); and the costs of post-graduate medical

education, in accordance with current DHCFP-403 reporting. In addition, the costs of nursing, allied health, and undergraduate medical education are also included.

Line 8 — Advertising and Marketing. Expenses related to attracting patients to the hospital or health system including, but not limited to, preparation and distribution of advertisements.

Line 9 — Board Designated–Assets by type and amount of each category of board designation. Assets restricted as to use by the Board of Trustees or by external parties such as bond issuers. The reported assets should be those associated with the reporting hospital. Assets of the parent or those controlled by the system's Board of Trustees are not applicable.

Line 10 — Bad Debt. The annual cost of the provision (estimate) and write-off (exact cost) of revenue for which the hospital is unable to collect payment, as currently reported on the DHCFP-403.

Line 11 — Charitable Contributions. Cash or non-cash donations to an unaffiliated organization which is designated as a 501c(3) non-profit, or government entity, and which is organized for charitable, religious, educational, health, or other good works. Also includes service provided to patients as charity care for whom the hospital has agreed not to bill any person or payer. Charitable contributions do not include contractual services, payments in lieu of taxes, CHIA's annual assessment, the Health Safety Net Assessment, discounts on services rendered, denied claims, bad debt or patient cost sharing.

Line 12 — Debt Service. Annual payments of interest and principal on total outstanding debt.

Line 13 — Depreciation. The annual cost of depreciation expenses, assuming the assets lose an equal amount of value each year (straight-line definition), as currently reported on the DHCFP-403.

Line 14 — Direct Labor. The cost of salaries, wages, and fringe benefits for hospital employees, including physician employees, as currently reported on the DHCFP-403.

Line 15 — Fundraising and Development. Expenses for activities undertaken to induce potential donors to contribute money, assets, or services.

Line 16 — Health Information Technology. Direct costs, including personnel costs, operating costs and depreciation associated with hardware and software

related to the patient care technology systems that provide the framework for comprehensive management of health information and its secure exchange between consumers, providers, government and quality entities, and insurers. It includes electronic medical records (EMR); clinical decision support (CDS); computerized physician order entry (CPOE); bar-coding at medication dispensing (BarD); robot for medication dispensing (ROBOT); automated dispensing machines (ADM); administration of EMR, bar-coding at medication administration (Bar-A); electronic health record (EHR), and any other point of care technology systems. The definition excludes general administrative cost systems, including, but not limited to, payroll, financial reporting, claims adjudication, and cost reporting.

Line 17-19 — Malpractice Insurance. The annual costs of premium payments for malpractice insurance and self-funded costs for malpractice liabilities, as currently reported on the DHCFP-403.

Line 21 — Medical Management Expenses. Direct expenses associated with providing an integrated care coordination delivery system intended to support an individual's health care needs across a continuum of care, including, but not limited to, direct costs of case managers, discharge planners, social workers, and interpreters.

Line 22 — Net Annual Transfers. The net amount of transfers between and among the hospital, its related physician organization, and other affiliated entities, including, but not limited to, transfers reported on the hospital's or physicians' organization balance sheet and the Changes in Net Assets on the hospital's or physicians' organization Statement of Operations.

Line 23 — Research. Formal and/or grant-funded research studies intended to further the scientific knowledge of diagnosis, treatment, cure and prevention of physical or mental disease, injury or deformity, relief of pain, and improvement and preservation of health.

Line 24 — Stop-Loss Insurance. Insurance coverage purchased to limit hospital losses for malpractice claims, capitation, and employee health insurance claims.

NET ANNUAL TRANSFERS BETWEEN ENTITIES

1. Providers must report the net annual amount of financial transfers between affiliated system entities and both the reporting hospital and the reporting hospital's affiliate physicians' organization(s).

2. A negative expense indicates that the hospital or physicians' organization(s) transfers assets to the entity. A positive expense indicates that the entity transfers assets to the hospital or physicians' organization(s).

Line 26, Column 4	No input required (net transfer between the Reporting Hospital and itself).
Line 26, Column 5	Net transfer between the Reporting Hospital and the Physicians' Organization of the Reporting Hospital.
Line 27 to 29, Col. 4	Net transfer between any system hospitals (specify each) and the Reporting Hospital.
Line 27 to 29, Col. 5	Net transfer between any system hospitals (specify each) and the Physicians' Organization of the Reporting Hospital.
Line 30 to 32, Col. 4	Net transfer between any system physicians' organizations (specify each) and the Reporting Hospital.
Line 30 to 32, Col. 5	Net transfer between any system physicians' organizations (specify each) and the Physicians' Organization of the Reporting Hospital.
Line 33 to 36, Col. 4	Net transfer between any other entities (specify each) and the Reporting Hospital.
Line 33 to 36, Col. 5	Net transfer between any other entities (specify each) and the Physicians' Organization of the Reporting Hospital.

BOARD DESIGNATED ASSETS BY TYPE AND AMOUNT

In Column 6, enter the amount associated with each of the following types of board designated assets:

Line 38	Assets held for restrictions on bond covenants
Line 39	Investment Collateral
Line 40	Funded depreciation
Line 41	Future capital improvements
Line 42	Working Capital
Line 43	Self-Insurance Reserves/Funding
Line 44	Board designations other than those listed above shall be combined into an "other" category.

Schedule XXVIII – 340B Pharmacy Annual Reporting (For hospital with 340 Pharmacy)

Part II. Pharmacy Staffing information: Enter direct staffing within Pharmacy.

Line 1 to 8: List the FTEs and expenses for salary (per position).

Line 10 and 11: List payroll taxes, and benefits.

Part III. Non-staffing Expenses: Allocate non-staffing expenses among categories:

Line 1 Sub-Contracted Pharmacy Expense:
Captures expenses from "off site" / "contracted" pharmacy arrangements.

Line 4 Prescription Supplies:
ONLY the cost of drugs

Line 5 Other Pharmacy Supplies:
Prescription Supplies and Other Medical Supplies roll up to be the "Medical Supplies" line.

Line 11 Depreciation:
Building and equipment

Line 12 Other:
Includes travel, legal, accounting, office supplies, etc.

Line 14 Administrative Allocation:
Estimate ¼ Administrative Allocation to be reported within annual cost report's Pharmacy cost center.

Part IV. Total Revenue: Report Gross Pharmacy Revenue.

Line 2 MassHealth Fee-For-Service / PCC Plan:
PCC Plan members and other MassHealth FFS members paid directly by MassHealth.

Line 3 MassHealth MCO:
MassHealth members enrolled in Neighborhood Health Plan, Boston Medical Center HealthNet Plan, Network Health or Fallon Community Health Plan.

Line 4 Commonwealth Care:
Commcare members enrolled in Neighborhood Health Plan, Boston Medical Center HealthNet Plan, Network Health or Fallon Community Health Plan.

Line 5 Commercial / Private Third Parties:

Neighborhood Health Plan (NHP Commercial Members Only), Blue Cross / Blue Shield, Tufts Health Plan, RX America, Unicare (Including CMSP and Health Start programs), etc.

Line 6 Health Safety Net (HSN):
Prescriptions that are dispensed to a HSN-eligible recipient and billed to the HSN according to 114.6 CMR 14.00 Health Safety Net Payments and Funding.

Line 7 Patient Assistance Program HSN eligible Recipients:
Prescriptions that are dispensed to a HSN-eligible recipient from donated drugs as part of the Patient Assistance Program (bulk replacements, patient assistance program, etc).

Line 8 Patient Assistance Programs:
Prescriptions that are disposed to a NON-DSH eligible recipient from donated drugs as part of a Patient Assistance Program (bulk replacements, patient assistance program, etc.)

Line 9 DPH Programs I:
Programs supported by DPH initiatives via funding (Family Planning, Refugee, HDAP,etc).

Line 10 DPH Programs II:
Supported by DPH initiatives that drugs are provided (TB Clinics,etc)

Line 11 State Capitated Programs:
Programs administered by capitated payment methods (CenterCare, PACE, SCO,etc).

Line 12 Patient Payment:
Payments from patients who pay for prescription without any other insurance or HSN payment.

Line 13 Other Patient Revenue:
Payments in the form of copays, co-insurance or partial payments for patients that use some other source as the primary payment (MassHealth, CommCare, Commercial, HSN,etc.)

Line 15 Donated Good & Services:
Should equal total of Donated Salaries and Donated Services listed within Part II and Part III.

Line 17 Other Income:
Includes grants.

1. Part V. Statistics

Line 1 to 13: Enter Number of Prescriptions for Brand and Generic.
Enter Ingredient Costs of Prescriptions for Brand and Generic.
Enter Revenue from Prescription for Brand and Generic.

Copay Statistics

Line 15 to 18: Enter Number of scripts requiring copay for Brand and Generic.
Enter Number of scripts for which copay was paid for Brand and Generic.
Enter Revenue gathered from copays for Brand and Generic.